Washington State Department of
Labor & Industries
Workers' Compensation Services

Payment Policies

for Services Provided to Injured Workers
and Victims of Crime

Effective July 1, 2011

Copyright Information

This document is also on the department's Internet web site at http://feeschedules.Lni.wa.gov/.

Updates to this manual can be found under 'Updates and Corrections' tab on the department's Internet web site at http://feeschedules.Lni.wa.gov/

Updates to this manual are also announced on the Medical Provider e-News listserv. Individuals may join the listserv at http://www.Lni.wa.gov/Main/Listservs/Provider.asp.

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How to Use This Manual

The *Medical Aid Rules and Fee Schedules* manual consists of several sections. Below are some tips on how to find the information you need.

SPECIFIC SECTIONS WITHIN THIS MANUAL

- Introduction – contains general policies that all providers need.
- Professional – contains information for individual professional providers.
- Facility – contains information necessary for facility providers.
- Appendices – contains compilation of coverage information pertaining to all sections.

SPECIFIC SECTIONS NOT CONTAINED WITHIN THIS MANUAL

- Fee Schedules – contains the fees associated with authorized billing codes.
- Field Key – contains the column headings and abbreviations for the Fee Schedules.
- Medical Aid Rules – contains L&I specific Washington Administrative Code (WAC).
- Updates and Corrections – contains any updates to policies and fees.
    - http://feeschedules.Lni.wa.gov/.

TO NAVIGATE THROUGH THIS MANUAL

- The Table of Contents – The page numbers are links to the page.
- The Index – The page numbers are links to the page.
- The **Bookmarks** tab (see the far left of this manual.) is a feature of Adobe Acrobat. You can use the bookmark links to jump around this manual. If the Bookmark tab isn't open you can open it by clicking on the **Bookmarks** tab.
    - Click on any text in the list to go to the information within this manual.
    - Click on the plus (+) sign to open each section's list for more information.
    - Click on the minus (-) sign to close the section.
- The Find box is another feature of Adobe Acrobat.
    - Follow the instructions to search for the item or topic you need.
- To search for a word, Press 'Ctrl+F'.
    - Follow the instructions to search for the item or topic you need.
- Use the two kinds of hyperlinks within this manual:
    - Internal jump links are similar to the bookmark links mentioned above.
    - Internet web sites always begin with http:// - These links will take you to the internet web site.

TO FIND INFORMATION ON A SPECIFIC PROCEDURE CODE

- Review the payment policy, (which is inside this manual).
- Review the fee schedule, (which is outside of this manual).

TO PRINT INFORMATION WITHIN THIS MANUAL

- Use the Print icon which is on the same menu as the Binocular Search icon.
    - This print feature will give you options specific to printing this Adobe Acrobat file (PDF) which allows you to print a specific page or the entire manual.

Highlights of Changes

This Medical Aid Rules and Fee Schedules (fee schedule) is effective for services provided on or after July 1, 2011. These highlights are intended for general reference; they are not a comprehensive list of all the changes in the fee schedule. Refer to the 2011 CPT© and HCPCS coding books for complete code descriptions and lists of new, deleted or revised codes.

WASHINGTON ADMINISTRATIVE CODE (WAC) AND PAYMENT CHANGES

- Cost of living adjustments were not applied to RBRVS and anesthesia services or to most local codes.
- WAC 296-20-135 reduces the RBRVS conversion factor to $55.34 while the anesthesia conversion factor remains at $3.19 per minute ($47.85 per 15 minutes).
- WAC 296-23-220 and WAC 296-23-230 maintain the maximum daily cap for physical and occupational therapy services at $118.07.
- WAC 296 -23 –250 set a daily cap for massage therapy of 75% of the daily cap for PT/OT services. The rate for July will remain $88.55.

POLICY & FEE SCHEDULE ADDITIONS, CHANGES AND CLARIFICATIONS

Introduction

- Added a new section addressing self-insurers.

Professional Services

- Updated the telephone call policy to cover detailed messages.
- Revised the list of injection codes that now include diagnostic imaging in the description.
- Revised the examples for billing physical therapy services.
- Expanded the work conditioning policy.
- Added a new policy on drug screens.
- Outlined coverage for buprenorphine and buprenorphine/naloxone.
- Independent Medical Exam section includes new codes for no shows for neuropsychological testing and PCEs scheduled by the department.
- Interpretive services section reflects new telephone interpreter services.

Facility Services

- Fees including Hospital AP-DRG and Per Diem rates have been updated.

Appendices

- Preferred Drug List has been updated.
- Other appendices have been updated with new codes.

Fee Schedules

- With the exception of the comma delimited files, the Field Keys are integrated into the fee schedules.
- A new fee schedule for medical and surgical supplies has been established for suppliers who routinely bill for these items. Items listed in the Professional Fee Schedule as bundled will remain bundled for other providers.
- The following fee schedules have been updated:
  - Professional fees.
  - Durable medical equipment fees.
  - Prosthetics and Orthotics fees.
  - Laboratory fees.
  - Pharmacy fees.
  - Dental fees.
  - Interpreter fees.
  - Hospital AP-DRG outlier thresholds.
  - Hospital percent of allowed charge (POAC) factors.
  - Hospital rates.
  - Hospital ambulatory payment classification (APC) rates.
  - Residential fees.
  - Ambulatory surgery center (ASC) fees.

Introduction

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the Medical Aid Rules and Fee Schedules (MARFS), and Provider Bulletins. If there are any services, procedures or text contained in the physicians' Current Procedural Terminology (CPT®) and federal Healthcare Common Procedure Coding System (HCPCS) coding books that are in conflict with MARFS, the Department of Labor and Industries' (L&I) rules and policies take precedence (WAC 296-20-010). All policies in this manual apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

For more information on L&I WACs go to
http://www.Lni.wa.gov/ClaimsIns/Rules/MedicalAid/default.asp

For more information on the Revised Code of Washington (RCW) go to
http://search.leg.wa.gov/pub/textsearch/default.asp

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

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GENERAL INFORMATION

EFFECTIVE DATE

This edition of the Medical Aid Rules and Fee Schedules (MARFS) is effective for services performed on or after July 1, 2011.

UPDATES AND CORRECTIONS TO THE FEE SCHEDULES

If necessary, corrections to MARFS will be published on L&I's web site at http://feeschedules.Lni.wa.gov/ under Fee Schedules/Updates & Corrections.

Additional fee schedule and policy information is published throughout the year in L&I's Provider Bulletins that are available at http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp

Interested parties may join the L&I Medical Provider News electronic mailing list at http://www.Lni.wa.gov/Main/Listservs/Provider.asp

Listserv participants will receive via e-mail:

- Updates and changes to the Medical Aid Rules and Fee Schedules.
- A link to the new Provider Bulletins as soon as they are posted.
- Notices about courses, seminars, and new information available on L&I's website.

STATE AGENCIES' FEE SCHEDULE AND PAYMENT POLICY DEVELOPMENT

Washington State government payers coordinate fee schedule and payment policy development. Billing and payment requirements are as consistent as possible for providers.

The state government payers are:

- The Washington State Fund Workers' Compensation Program administered by the Department of Labor and Industries (L&I).
- The State Medicaid Program administered by the Medical Purchasing Administration within the Health Care Authority.

These agencies comprise the interagency Reimbursement Steering Committee (RSC). The RSC receives input from the State Agency Technical Advisory Group (TAG) on the development of fee schedules and payment policies. The TAG consists of representatives from almost all major state professional provider associations.

While the basis for most of the agencies' fee schedules is the same, payment and benefit levels differ because each agency has its own funding source, benefit contracts, rates and conversion factors.

PAYMENT REVIEW

All services rendered to workers' compensation claims are subject to audit by L&I. See RCW 51.36.100 and RCW 51.36.110.

HEALTH CARE PROVIDER NETWORKS

The Revised Code of Washington (RCW) and the Washington Administrative Code (WAC) allow L&I and self-insured employers (collectively known as the insurer) to recommend particular providers or to contract for services. Workers are responsible for choosing their providers. RCW 51.04.030 (2) allows the insurer to recommend to the worker particular health care services or providers where specialized or cost effective treatment can be obtained. However, RCW 51.28.020 and RCW 51.36.010 stipulate that workers are to receive proper and necessary medical and surgical care from licensed providers of their choice.

MAXIMUM FEES NOT MINIMUM FEES

L&I establishes maximum fees for services; it doesn't establish minimum fees.

RCW 51.04.030 (2) states that L&I shall, in consultation with interested persons, establish a fee schedule of maximum charges. This same RCW stipulates that no service shall be paid at a rate or rates exceeding those specified in such fee schedule. WAC 296-20-010(2) reaffirms that the fees listed in the fee schedule are maximum fees.

BECOMING A PROVIDER

Health care providers can use the same L&I provider number to bill for treating State Fund injured workers and crime victims. New providers can sign up for both programs at the same time using one provider application.

WORKERS' COMPENSATION PROGRAM

A provider must have an active L&I provider account number in order to treat Washington workers and receive payment for medical services. For State Fund claims, this proprietary account number is necessary for L&I to accurately set up its automated billing systems. Once the L&I provider account number is established, and the federally-issued National Provider Identifier (NPI) is registered with L&I, either number can be used on bills and correspondence submitted to L&I. All L&I providers must comply with all applicable state and/or federal licensing or certification requirements to assure they are qualified to perform services. This includes state or federal laws pertaining to business and professional licenses as they apply to the specific provider's practice or business.

Providers can apply for:

- L&I provider account numbers by completing the Provider Account Application and W-9 (form F248-011-000). *These forms are available at* http://www.becomeprovider.Lni.wa.gov or can be requested by contacting L&I's Provider Accounts section or the Provider Hotline.
- NPIs at https://nppes.cms.hhs.gov/NPPES/Welcome.do .

Contact Information

Provider Accounts
Department of Labor & Industries
PO Box 44261
Olympia, WA 98504-4261
360-902-5140

Provider Hotline
1-800-848-0811

More information about the provider account application process is published in WAC 296-20-12401.

KEEP YOUR PROVIDER ACCOUNT UPDATED

Keep us informed of your account changes to prevent payment delays by completing a Provider Accounts Change Form (form F245-365-000) available at http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1650 . Providers with active L&I provider accounts are listed on Find-a-Doctor (FAD) at http://www.Lni.wa.gov/ClaimsIns/Claims/FindaDoc/Default.asp unless they indicate on their application they don't wish to be included on FAD. Accurate information helps ensure smooth communication between you, L&I, workers and employers.

For self-insured workers' compensation claims contact the insurer directly for provider account number requirements. For assistance in locating self-insurers go to:

http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

CRIME VICTIMS COMPENSATION PROGRAM

A provider treating crime victims must apply for a provider account number. The Provider Application and W-9 (form F800-053-0000) are available on L&I's web site at http://www.becomeprovider.Lni.wa.gov or can be requested by contacting L&I's Provider Accounts section or the Provider Hotline.

Provider resources for the Crime Victims Compensation Program are available on L&I's web site at http://www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/Default.asp. Providers with active Crime Victims Compensation Program accounts are listed on Find-a-Doctor for Crime Victims at https://fortress.wa.gov/lni/fad/FADCSearch.aspx unless they indicate on their application they don't wish to be included on Find-a-Doctor.

Contact Information

Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520
1-800-762-3716

SELF-INSURANCE

Self-insured employers (SIE) or their third party administrators (TPA), administer their own claims, instead of paying premiums to the State Fund for L&I to administer.

- SIEs must authorize treatment and pay bills according to Title 51 RCW and the Medical Aid Rules (WACs) and Fee Schedules of the state of Washington (WAC 296-15-330(1)).
- Health care providers should send their bills, reports, requests for authorization etc., directly to the SIE/TPA.
- For a list of SIE/TPAs go to: http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

SIEs use the Self Insurance Accident Report (SIF2).

- The SIF2 is the form used to assign the claim number.
- Only the SIE and the worker complete the SIF2.
- Employers: To order a supply of SIF2s go to: http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2466

Provider's Initial Report (PIR) forms are supplied to providers to assist injured workers of SIEs in filing claims.

- The PIR is used in the same way the Report of Accident (ROA) form is used for State Fund covered workers.
- Only the provider and the worker complete the PIR.
- Providers: To order a supply of PIRs go to: http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2467

The Self-Insurance (SI) Program of L&I regulates the SIEs. If a dispute arises between a provider and an SIE, the provider may ask the SI program to intervene and help resolve the dispute.

- For disputes related to treatment authorization or nonpayment of bills, the SI section's adjudicator assigned to the claim will handle the request.
- For disputes related to billing codes, fees, and/or payment policies, the SI section's Medical Compliance Consultant will handle the request.

BILLING INSTRUCTIONS AND FORMS

WHO TO BILL

State Fund Claims begin with the letters **B**, **C**, **F**, **G**, **H**, **J**, **K**, **L**, **M**, **N**, **P**, **X**, or **Y** followed by six digits, or **double alpha letters** (example AA) followed by five digits. **Self-insured claims** begin with an **S**, **T** or **W** followed by six digits or **double alpha letters** (example SA) followed by five digits. U. S. Department of Energy (DOE) claims are now self-insured. **Crime Victims claims** begin with a **V** followed by six digits, or **double alpha letters** (example VA) followed by five digits.

Federal claims begin with **A13** or **A14**. Questions and billing information about federal claims should be directed to the U.S. Department of Labor at (206) 398-8100 or (206) 398-8200 or their web site at http://www.dol.gov/owcp/.

BILLING PROCEDURES

Billing procedures are outlined in WAC 296-20-125.

BILLING MANUALS AND BILLING INSTRUCTIONS

The *General Provider Billing Manual* (publication F248-100-000) and L&I's provider specific billing instructions contain billing guidelines, reporting and documentation requirements, resource lists and contact information. Providers can download these manuals on L&I's web site at http://www.Lni.wa.gov/FormPub/ or request these publications from L&I's Provider Accounts section or the Provider Hotline. (See the Becoming a Provider section above for contact information.)

BILLING WORKSHOPS

L&I offers providers free billing workshops to help you save time and money by:

- Learning to bill L&I correctly
- Getting new tools for doing business with L&I
- Meeting your Provider Account Representatives

Additional information on the workshops is available at http://www.lni.wa.gov/ClaimsIns/Providers/Billing/Workshop/default.asp.

ELECTRONIC BILLING FOR STATE FUND BILLS

Electronic billing is available to all providers of services to injured workers covered by the State Fund.
Electronic billing allows greater control over the payment process eliminating entry time and allowing L&I to process payments faster than paper billing. It reduces billing errors and decreases the costs of bill processing. See Cost Comparison Estimator at http://www.Lni.wa.gov/ClaimsIns/Files/providers/EstimatorFinal042009.xls

There are three secure ways providers can bill L&I electronically:

- Free on-line billing form.
  Note: No specific software/clearinghouse required.
- Upload bills using your software.
  Note: The department doesn't supply billing software for electronic billing.
- Use an intermediary/clearinghouse

Your correspondence and reports may be faxed to L&I. Fax numbers can be found on page **15** or L&I's web site at http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/How/default.asp.

For additional information on electronic billing, go to:
www.ElectronicBilling.Lni.wa.gov

Or contact the Electronic Billing Unit at:

Electronic Billing
Phone: (360) 902-6511
Fax: (360) 902-6192
E-mail: ebulni@LNI.wa.gov

BILLING FORMS

Providers must use L&I's current billing forms. Using out-of-date billing forms may result in delayed payment. To order new billing forms or other L&I publications, complete the "Medical Forms Request" (Form F208-063-000) (located under Contact Information on the MARFS CD or on L&I's web site at http://www.Lni.wa.gov/Forms/pdf/208063a0.pdf and send it to L&I's warehouse (address listed on the form). You may also download many forms from L&I's web site at http://www.Lni.wa.gov/FormPub/.

GENERAL BILLING TIPS

This symbol is placed next to billing tips throughout the policy sections to facilitate billing correctly.

ADJUSTMENT VS. SUBMITTING A NEW BILL TO THE STATE FUND

- When an entire bill is denied, you need to submit a new bill to be paid for your services.
- When part of the bill is paid, you must submit an adjustment for the services which weren't paid. Additional information on adjustments is available at

http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/default.asp .

FAILURE TO ATTEND SCHEDULED APPOINTMENT

Workers are expected to attend scheduled appointments. When a worker fails to show for an appointment:

- Per WAC 296-20-010(5) "No fee is payable for missed appointments unless the appointment is for an examination arranged by L&I or self-insurer."
- Workers are advised that a no-show appointment may be grounds for a non-cooperation order.
- Providers are to notify the claim manager immediately when an injured worker fails to show for an appointment.

SUBMITTING CLAIM DOCUMENTS TO THE STATE FUND

Submitting State Fund bills, reports and correspondence to the correct addresses helps L&I pay you promptly.

Please don't fax bills. You may fax correspondence and reports to the FAX Numbers listed in this section.

NOTE: Attending providers have the ability to send secure messages through the Claim and Account Center at http://www.Lni.wa.gov/ORLI/LoGon.asp.

Item	FAX Numbers	State Fund Mailing Address
Report of Industrial Injury or Occupational Disease – Accident Report F242-130-000	ROAs ONLY (360) 902-6690 (800) 941-2976	Department of Labor & Industries PO Box 44299 Olympia, WA 98504-4299
Correspondence, Activity Prescription Forms, reports and chart notes for State Fund Claims and claim related documents other than bills.	(360) 902-4567	Department of Labor & Industries PO Box 44291 Olympia, WA 98504-4291 **Reports and chart notes must be submitted separately from bills.**
Provider Account information updates	(360) 902-4484	Department of Labor & Industries PO Box 44261 Olympia, WA 98504-4261
UB-04 Forms CMS 1500 Forms Retraining & Job Modification Bills Home Nursing Bills Miscellaneous Bills Pharmacy Bills Compound Prescription Bills Requests for Adjustment	**Don't fax bills**	Department of Labor & Industries PO Box 44269 Olympia, WA 98504-4269
State Fund Refunds (attach copy of remittance advice)	N/A	Cashier's Office Department of Labor & Industries PO Box 44835 Olympia, WA 98504-4835

TIPS FOR SUBMITTING DOCUMENTS TO THE STATE FUND

The State Fund uses an imaging system to store electronic copies of all documents submitted on workers' claims. This system can't read some types of paper and has difficulty passing other types through automated machinery. Documents faxed to the department are automatically routed to the claim file; paper documents are batched and scanned when time is available.

Do's

These tips can help L&I process your documents promptly and accurately.

- Put the patient's name and claim number in the upper right hand corner of each page.
- Submit documents on white 8 ½ x 11-inch paper (one-side only).
- Leave ½ inch at the top of the page blank.
- Submit legible information.
- If there is no claim number available, substitute the patient's social security number.
- Emphasize text using asterisks or underlines.
- Staple together all documents pertaining to one claim.
- Include a key to any abbreviations used.
- Reference only one worker/patient in a report or letter.

Don'ts

Please **don't**:

- Use colored paper, particularly hot or intense colors.
- Use thick or textured paper.
- Send carbonless paper.
- Use any highlighter markings.
- Place information within shaded areas.
- Use italicized text.
- Use paper with black or dark borders, especially on the top border.
- Staple documents for different workers/patients together.

Following the above tips can prevent significant delays in claim management and bill payment, and can help you avoid repeated requests for information you have already submitted.

DOCUMENTATION REQUIREMENTS

Providers must maintain documentation in workers' individual records to verify the level, type and extent of services provided to workers. The insurer may deny or reduce a provider's level of payment for a specific visit or service if the required documentation isn't provided or the level or type of service doesn't match the procedure code billed. No additional amount is payable for documentation required to support billing.

Providers can submit forms with a signature stamp or an electronic signature from the medical provider. The insurer **won't pay** for forms unless they are signed by the provider or authorized representative.

In addition to the documentation requirements published by the American Medical Association (AMA) in the CPT® book, the insurer has additional reporting and documentation requirements. These requirements are described in the provider specific sections of this document (MARFS) and in WAC 296-20-06101. The insurer may pay separately for specialized reports or forms required for claims management. For specific documentation requirements see **Appendix G**.

Amendment of Medical Records
(Policy is based on American Health Information Management Association (AHIMA) and Centers for Medicare & Medicaid Services (CMS) guidelines.)

Changes to the medical record legally amended prior to bill submission may be considered in determining the validity of the services billed. Changes made after bill submission won't be accepted. If a change to the medical record is made after bill submission, only the original record will be considered in determining appropriate payment of services billed to the department.

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation or clinical services. A **late entry**, **addendum** or **correction** to the medical record must bear the current date of that entry and be signed by the person making the addition or change.

A **late entry** may be necessary to supply additional information that was omitted from the original entry or to provide additional documentation to supplement entries previously written. The late entry must bear the current date, be added as soon as possible, be written by the provider who performed the original service and only if the provider has total recall of the omitted information.
To document a late entry:

- Identify the new entry as a "late entry".
- Enter the current date and time- don't try to give the appearance that the entry was made on a previous date or an earlier time,
- Identify or refer to the date and incident for which the late entry is written.
- If the late entry is used to document an omission, validate the source of additional documentation as much as possible.

An **addendum** is used to provide information that wasn't available at the time of the original entry.
To document an addendum:

- Identify the entry as an "addendum" and state the reason for the addendum referring back to the original entry.
- Document the current date and time.
- Identify any sources of information used to support the addendum.

A **correction** to the medical record requires that proper error correction procedures are followed.

- Draw a line through the entry making sure that the inaccurate information is still legible.
- Initial and date the entry.
- State the reason for the error.
- Document the correct information.

Correction of electronic medical records should follow the same principles of tracking the information.

Falsified Documentation

Deliberately falsifying medical records is a felony offense and is viewed seriously when encountered (RCW 51.48.290, 51.48.250). Some examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or
- Adding to existing documentation (except as described in late entries, addendums and corrections)

RECORD KEEPING REQUIREMENTS

As a provider with a signed agreement with L&I, you are the legal custodian of workers' records. You must include subjective and objective findings, records of clinical assessment (diagnoses), reports, interpretations of X-rays, laboratory studies and other key clinical information in patient charts.

Providers are required to keep all records necessary for L&I to audit the provision of services for a minimum of 5 years (See WAC 296-20-02005).

Providers are required to keep all X-rays for a minimum of 10 years (See WACs 296-20-121 and 296-23-140).

DOCUMENTATION REQUIREMENTS WHEN REFERRING WORKER OUTSIDE OF LOCAL COMMUNITY FOR CARE

Whenever it is necessary to refer an injured worker for specialty care or services outside of the local community, include in the medical notes the medical reason for the referral, and a **statement of why it is reasonable or necessary to refer outside of the community**.

CHARTING FORMAT

For charting progress and ongoing care, use the standard **SOAP** (Subjective, Objective, Assessment, and Plan and progress) format.

In workers' compensation there is a unique need for work status information. To meet this need, L&I requires that you add **ER** to the SOAP contents.

Chart notes must document:

E Employment issues

- Has the worker been released or returned to work?
- When is release anticipated?
- Is the patient currently working, and if so, at what job?
- Include a record of the patient's physical and medical ability to work.
- Include information regarding any rehabilitation that the worker may need to undergo.

R Restrictions to recovery

- Describe the physical limitations (temporary and permanent) that prevent return to work.
- What other limitations, including unrelated conditions, are preventing return to work?
- Are any unrelated condition(s) impeding recovery?
- Can the worker perform modified work or different duties while recovering (including transitional, part-time, or graduated hours)?
- Is there a need for return-to-work assistance?

SOAP-ER CHARTING FORMAT

Office/chart/progress notes and 60-day reports should include the SOAP contents:

S Worker's Subjective complaints

What the worker states, or what the employer, coworker or significant other (family, friend) reports, about the illness or injury. Refer to WAC 296-20-220 (j).

O Objective findings

What is directly observed and noticeable by the medical provider. This includes factual information, for example, physical exam – skin is red and edematous, lab tests – positive for opiates, X-rays – no fracture. Refer to WAC 296-20-220 (i).

A Assessment

What conclusions the medical provider makes after evaluating all the subjective and objective information. Conclusions may appear as:

- A definite diagnosis (dx.),
- A "Rule/Out" diagnosis (R/O), or
- Simply as an impression.

This can also include the etiology (ET), defined as the origin of the diagnosis; and/or prognosis, defined as being a prediction of the probable course or a likelihood of recovery from a disease and/or injury.

P Plan and Progress

What the provider recommends as a plan of treatment. This is a goal directed plan based on the assessment. The goal must state what outcome is expected from the prescribed treatment and the plan must state how long the treatment will be administered.

Clearly state treatment performed and treatment plan separately. You must document the services you perform to verify the level, type, and extent of services provided to workers. Refer to WAC 296-20-010(7) and WAC 296-20-01002 (Chart notes).

Add **ER** to the SOAP contents to document work status information.

OVERVIEW OF PAYMENT METHODS

HOSPITAL INPATIENT PAYMENT METHODS

The following is an overview of L&I's hospital inpatient payment methods. See the Facility Services section, page **187**, or refer to Chapter 296-23A WAC for more information.

Self-insurers (see WAC 296-23A-0210)

Self-insurers use Percentage of Allowed Charges (POAC) to pay for all hospital inpatient services.

All Patient Diagnosis Related Groups (AP DRG) (See WAC 296-23A-0200)

L&I uses All Patient Diagnosis Related Groups (AP DRG) to pay for most inpatient hospital services.

Per Diem

L&I uses statewide average per diem rates for 5 AP DRG categories:

- Chemical dependency
- Psychiatric
- Rehabilitation
- Medical
- Surgical

Hospitals paid using the AP DRG method are paid per diem rates for AP DRGs designated as low volume.

Percent of Allowed Charges (POAC)

L&I uses a POAC payment method:

- For some hospitals exempt from the AP DRG payment method
- As part of the outlier payment calculation for hospitals paid by the AP DRG

HOSPITAL OUTPATIENT PAYMENT METHODS

The following is an overview of L&I's payment methods for hospital outpatient services. Refer to Chapter 296-23A WAC and the Facility Services section for more information.

Self-insurers (see WAC 296-23A-0221)

Self-insurers use the maximum fees in the Professional Services Fee Schedule to pay for:

- Radiology,
- Pathology,
- Laboratory,
- Physical therapy and
- Occupational therapy services

Self-insurers use POAC to pay for hospital outpatient services that aren't paid with the Professional Services Fee Schedule.

Ambulatory Payment Classifications (APC) (See WAC 296-23A-0220)

L&I pays for most hospital outpatient services with the Ambulatory Payment Classifications (APC) payment method.

Professional Services Fee Schedule

L&I pays for most services not paid with the APC payment method according to the maximum fees in the Professional Services Fee Schedule.

Percent of Allowed Charges (POAC)

Hospital outpatient services are paid by a POAC payment method when they **aren't paid**

- With the APC payment method,
- The Professional Services Fee Schedule or
- By L&I contract.

Out-of-State Hospital Payment Methods

See WAC 296-23A-0230 for out-of-state hospital outpatient, inpatient, and professional services payment methods.

AMBULATORY SURGERY CENTER PAYMENT METHODS

Ambulatory Surgery Center (ASC) Rate Calculations

Insurers use a modified version of the ASC payment system that was developed by the Centers for Medicare and Medicaid Services (CMS) to pay for facility services in an ASC. Refer to Chapter 296-23B WAC in the Medical Aid Rules and the Facility Services section for more information.

By Report

Insurers pay for some covered services on a by report basis as defined in WAC 296-20-01002. Fees for by report services may be based on the value of the service as determined by the report.

Maximum Fees

L&I establishes rates for some services that are not priced with other payment methods.

PAIN MANAGEMENT PAYMENT METHODS

Chronic Pain Management Program Fee Schedule

Insurers pay for Chronic Pain Management Program Services using an all inclusive, phase-based, per diem fee schedule.

RESIDENTIAL FACILITY PAYMENT METHODS

Boarding Homes and Adult Family Homes

Insurers use per diem fees to pay for medical services provided in Boarding Homes and Adult Family Homes.

Nursing Homes, Transitional Care Units and Critical Access Hospitals utilizing swing beds for long term care

Insurers use modified Resource Utilization Groups (RUGs) to develop daily per diem rates to pay for Nursing Home Services.

PROFESSIONAL PROVIDER PAYMENT METHODS

Refer to Chapters 296-20, 296-21 and 296-23 WAC and the Professional Services section for more information.

Resource Based Relative Value Scale (RBRVS)

Insurers use the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. More information about RBRVS is contained in the Professional Services section. Services priced according to the RBRVS fee schedule have a fee schedule indicator of **R** in the Professional Services Fee Schedule.

Anesthesia Fee Schedule

Insurers pay for most anesthesia services using anesthesia base and time units. More information is available in the Professional Services section.

Pharmacy Fee Schedule

Insurers pay pharmacies for drugs and medications according to the pharmacy fee schedule. More information is available in the Professional Services section.

Average Wholesale Price (AWP)

L&I's maximum fees for some covered drugs administered in or dispensed from a prescriber's office are priced based on a percentage of the AWP of the drug. Drugs priced with an AWP method have AWP in the Dollar Value columns and a **D** in the fee schedule indicator column of the Professional Services Fee Schedule.

Clinical Laboratory Fee Schedule

L&I's clinical laboratory rates are based on a percentage of the clinical laboratory rates established by CMS. Services priced according to L&I's clinical laboratory fee schedule have a fee schedule indicator of **L** in the Professional Services Fee Schedule.

Flat Fees

L&I establishes rates for some services that are priced with other payment methods. Services priced with flat fees have a fee schedule indicator of **F** in the Professional Services Fee Schedule.

State Fund Contracts

State Fund pays for utilization management services by contract. Services paid by contract have a fee schedule indicator of **C** in the Professional Services Fee Schedule.

The Crime Victims Compensation Program doesn't contract for these services.

By Report

Insurers pay for some covered services on a by report basis as defined in

WAC 296-20-01002. Fees for by report (BR) services may be based on the value of the service as determined by the report. Services paid by report have a fee schedule indicator of **N** in the Professional Services Fee Schedule and BR in other fee schedules.

Program Only

Insurers pay for some unique services under specific programs. Examples include:

- Centers for Occupational Health Education
- Orthopedic and Neurological Surgeon Quality Pilot

BILLING CODES AND MODIFIERS

L&I's fee schedules use the federal HCPCS and agency unique local codes.

> **NOTE:** There are no descriptions for CPT® codes and only partial descriptions of HCPCS or CDT codes in the fee schedule. Providers must bill according to the full text descriptions published in the CDT-3®, CPT® and HCPCS books. These can be purchased from private sources. Refer to WAC 296-20-010(1) for additional information.

HCPCS (commonly pronounced Hick-Picks), Level I codes are the CPT® codes developed, updated and copyrighted annually by the American Medical Association (AMA.) There are 3 categories of CPT® codes:

- **CPT® Category I** codes are used for professional services and pathology and laboratory tests. These are clinically recognized and generally accepted services, not newly emerging technologies. They consist of 5 numbers (for example, 99201).
- **CPT® Category II** codes are optional and used to facilitate data collection for tracking performance measurement. They consist of 4 numbers followed by an **F** (for example, 0001F).
- **CPT® Category III** codes are temporary and used to identify new and emerging technologies. They consist of 4 numbers followed by a **T** (for example, 0001T).

HCPCS Level I modifiers are the CPT® modifiers that are developed, updated and copyrighted by the AMA. These are used to indicate that a procedure or service has been altered without changing its definition. They consist of 2 numbers (for example, –22). **L&I doesn't accept the 5 digit modifiers.**

HCPCS Level II codes are updated by the Center for Medicare & Medicaid Services (CMS).

HCPCS codes are used to identify:

- Miscellaneous services
- Supplies
- Materials
- Drugs
- Professional services

These codes begin with 1 letter, followed by 4 numbers (for example, K0007).

Codes beginning with **D** are developed and copyrighted by the American Dental Association (ADA) and are published in the *Current Dental Terminology* (CDT-3).

HCPCS Level II modifiers are updated by CMS and are used to indicate that a procedure has been altered. They consist of 2 letters (for example, –AA) or 1 letter and 1 number (for example, –E1).

Local codes are used to identify unique services or supplies. They consist of 4 numbers followed by 1 letter (except F and T). For example, 1040M must be used to code completion of the Report of Accident and Providers Initial Report forms. L&I will modify local code use as national codes become available.

Local modifiers are used to identify modifications to services. They consist of 1 number and 1 letter (for example, –1S). L&I will modify local modifier use as national modifiers become available.

REFERENCE GUIDE FOR CODES AND MODIFIERS

	HCPCS Level I			HCPCS Level II	
	CPT® Category I	**CPT® Category II**	**CPT® Category III**	**HCPCS**	**L&I Unique Local Codes**
Source	AMA / CMS	AMA / CMS	AMA / CMS	AMA / CMS	L&I
Code Format	5 numbers	4 numbers followed by F	4 numbers followed by T	1 letter followed by 4 numbers	4 numbers followed by 1 letter (not F or T)
Modifier Format	2 numbers	N/A	N/A	2 letters or 1 letter followed by 1 number	1 number followed by 1 letter
Purpose	Professional services, pathology and laboratory tests	Tracking codes to facilitate data collection for tracking performance measurement	Temporary codes for new and emerging technologies	Miscellaneous services, supplies, materials, drugs and professional services	L&I unique services, materials and supplies

CURRENT PROVIDER BULLETINS

Provider Bulletins are temporary communications that give official notification of new or revised rules, laws, coverage decisions, policies, and/or programs that haven't been previously published.

Current Provider Bulletins are available on L&I's web site at http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp.

NOTE: If a Provider Bulletin isn't listed on L&I's web site, it is no longer current or available. Its content was incorporated into coverage decisions, payment policies, and fee schedules.

CURRENT COVERAGE DECISIONS FOR MEDICAL TECHNOLOGIES & PROCEDURES

The following coverage decisions were made by the Office of the Medical Director. See L&I's web site at http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/default.asp for more information.

Coverage Decisions for Medical Technologies & Procedures
This information is current as of March 16, 2011.

Topic	Covered by workers compensation?			
	Yes			No
	With proper documentation	Only with pre-authorization	On a case-by-case basis	
Acupuncture				X
AquaMED (or dry hydrotherapy)	X			
Artificial disc replacement		X		
Autologous blood injections				X
Autologous chondrocyte implantation (ACI)		X		
Bloodborne pathogens	X			
Bone cements for use during kyphoplasty and vertebroplasty				X
Bone growth stimulators		X		
Bone morphogenic proteins (BMP) for long bone nonunions and spinal fusions		X		
Botulinum toxin		X		

Covered by workers compensation?				
Topic	Yes			No
	With proper documentation	Only with pre-authorization	On a case-by-case basis	
Brevio® Nerve Conduction Testing System				X
Cervical traction devices	X			
Ctrac[tm] for CTS wrist splint				X
Discography		X		
Dry needling		X		
Duragesic			X	
Electrical Stimulation for Chronic Wounds		X		
Electrodiagnostic Sensory Nerve Conduction Threshold (sNCT)				X
Electrodiagnostic Testing	X			
Epidural adhesiolysis		X		
ERMI Flexionator and Extensionater				X
Extracorporeal Shockwave Therapy (ESWT)				X
Fibromyalgia				X
Futures Unlimited	X			
Hyaluronic acid		X		
IDET (Intradiscal heating)				X
Implantable Drug Delivery Systems			X	
Influenza Claims		X		
Low level laser therapy				X
Knee Arthroscopy (for osteoarthritis of the knee)				X
MedX lumbar extension machine	X			
Meniscal allograft transplantation		X		
Microprocessor-controlled prosthetic knees				X
NC-stat® Nerve Conduction System-NeuroMetrix®				X
Neuromuscular electrical stimulators (NMES)	X(clinical use)	X (home use)		
Otto Bock Vacuum Assisted Socket System				X
Percutaneous Discectomy for Disc Herniation				X
Percutaneous Neuromodulation Therapy for low back pain				X
Posterior Lumbar Interbody Fusion (PLIF)		X		
Powered Traction Devices for Intervertebral Decompression	X			
Quantitative Sensory Testing (QST)				X
Smoking cessation		X		
Spinal Cord Stimulation				X
Standing, Weight-bearing, Positional & Upright[tm] MRI				X
Transcutaneous, Interferential and Percutaneous Electrical Nerve Stimulators (TENS)				X
Thermal shrinkage for instability				X
Tinnitus Retraining Therapy				X
UniSpacer				X
Wound VAC			X	
X-STOP® interspinous process device				X

Professional Services

This section contains payment policy information for professional services. Many of the policies contain information previously published in Provider Bulletins.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the Medical Aid Rules and Fee Schedules (MARFS) and Provider Bulletins. If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with MARFS, L&I's rules and policies take precedence (WAC 296-20-010). All policies in this document apply to workers or crime victims receiving benefits from the State Fund, the Crime Victims Compensation Program and self-insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

Copyright Information

This document is also on L&I's Internet site
http://feeschedules.Lni.wa.gov/
Updates to this manual can be found on L&I's web site
http://feeschedules.Lni.wa.gov/

Updates to this manual are also announced on the Medical Provider e-News listserv. Individuals may join the listserv at
http://www.Lni.wa.gov/Main/Listservs/Provider.asp.

PROFESSIONAL SERVICES TABLE OF CONTENTS

GENERAL INFORMATION

COVERED SERVICES

L&I makes general policy decisions, called medical coverage decisions, to ensure quality of care and prompt treatment of workers. Medical coverage decisions include or exclude a specific health care service as a **covered** benefit.

Procedure codes listed as **not covered** in the fee schedules aren't **covered** for the following reasons:

1. The treatment isn't safe or effective; or is controversial, obsolete, investigational or experimental.
2. The procedure or service is generally not used to treat industrial injuries or occupational diseases.
3. The procedure or service is payable under another code.

The insurer may pay for procedures in the first 2 categories above on a case-by-case basis. The health care provider must:

- Submit a written request and
- Obtain approval from the insurer prior to performing any procedure in these categories.

The request must contain:

- The reason,
- The potential risks and expected benefits,
- The relationship to the accepted condition and
- Any additional information about the procedure that may be requested by the insurer.

For more information on coverage decisions and covered services, refer to WAC 296-20 sections -01505, -02700 through -02850, -030, -03001, -03002 and -1102.

UNITS OF SERVICE

Payment for billing codes that don't specify a time increment or unit of measure is limited to 1 unit per day. For example, only 1 unit is payable for CPT® code 97022 regardless of how long the therapy lasts.

UNLISTED CODES

A covered service or procedure may be provided that doesn't have a specific code or payment level listed in the fee schedules. When reporting such a service, the appropriate unlisted procedure code may be used and a special report is required as supporting documentation. No additional payment is made for the supporting documentation. Refer to Chapter 296-20 WAC (including the definition section) and to the fee schedules for additional information.

PHYSICIAN ASSISTANTS

Physician assistants (PAs) must be certified and have valid individual L&I provider account numbers to be paid for services. PAs must bill for services using their provider account numbers. PAs should use billing modifiers outlined in the RBRVS Payment Policies Section of MARFS. For example, to bill for Assistant at Surgery, the PA would use modifier –80, –81 or –82 as appropriate.

Physician assistants may sign any documentation required by the department. Consultations and impairment ratings services related to workers' compensation benefit determinations aren't payable to physician assistants as specified in RCW 51.28.100 and WAC 296-20-01501.

Physician assistant services are paid to the supervising physician or employer at a maximum of 90% of the allowed fee. For more information about physician assistant services and payment, see WAC 296-20-12501 and WAC 296-20-01501.

WASHINGTON RBRVS PAYMENT SYSTEM AND POLICIES

L&I uses the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. These services have a fee schedule indicator (FSI) of **R** in the Professional Services Fee Schedule.

BASIS FOR CALCULATING RBRVS PAYMENT LEVELS

RBRVS fee schedule allowances are based on:

- Relative value units (RVUs),
- Geographic adjustment factors for Washington State and
- A conversion factor.

The maximum fee for a procedure is obtained by multiplying the adjusted RVU by the conversion factor. The maximum fees are published as dollar values in the Professional Services Fee Schedule.

Under the Centers for Medicare and Medicaid Services (CMS) approach, RVUs are assigned to each procedure based on the resources required to perform the procedure, comprised of:

- The work,
- Practice expense and
- Liability insurance (malpractice expense).

A procedure with an RVU of 2 requires half the resources of a procedure with an RVU of 4.

Geographic adjustment factors are used to correct for differences in the cost of operating in different states and metropolitan areas producing an adjusted RVU described below.

The conversion factor is published in WAC 296-20-135. It has the same value for all services priced according to the RBRVS. L&I may annually adjust the conversion factor by a process defined in WAC 296-20-132.

Two state agencies, L&I and Department of Social and Health Services (DSHS), use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

The primary source for the current RVUs is the 2011 Medicare Physician Fee Schedule Database (MPFSDB), which was published by CMS in the January 11, 2011 *Federal Register*. The *Federal Register* can be accessed online at http://www.gpoaccess.gov/fr/index.html or can be purchased from the U.S. government in hard copy, microfiche or disc formats. The *Federal Register* can be ordered from the following addresses:

Superintendent of Documents
PO Box 371954
Pittsburgh, PA 15250-7954

or http://bookstore.gpo.gov/

The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State. The Washington State geographic adjustment factors for July 1, 2011 are:

- 100.4% of the work component RVU,
- 102.2% of the practice expense RVU and
- 77.4% of the malpractice RVU.

To calculate the insurer's maximum fee for each procedure:

1. Multiply each RVU component by its geographic adjustment factor,
2. Sum the geographically adjusted RVU components, rounding to the nearest hundredth,
3. Multiply the rounded sum by L&I's RBRVS conversion factor (published in WAC 296-20-135) and round to the nearest penny.

SITE OF SERVICE PAYMENT DIFFERENTIAL

The site of service differential is based on CMS's payment policy. The insurer will pay professional services at the RBRVS rates for facility and nonfacility settings based on where the service was performed. Therefore, it is important to **include a valid 2-digit place of service code on your bill**.

The maximum fees for facility and nonfacility settings are published in the Professional Services Fee Schedule.

Services Paid at the RBRVS Rate for Facility Settings

When services are performed in a facility setting, the insurer makes 2 payments, one to the professional provider and another to the facility. The payment to the facility includes:

- Resource costs such as labor,
- Medical supplies and
- Medical equipment.

To avoid duplicate payment of resource costs, these costs are excluded from the RBRVS rates for professional services in facility settings.

Professional services billed with the following place of service codes will be paid at the rate for facility settings:

Place of Service Code	Place of Service Description
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgery center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
34	Hospice
41	Ambulance (land)
42	Ambulance (air or water)
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
99	Other unlisted facility
(none)	(Place of service code not supplied)

Remember to include a valid 2-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

Services Paid at the RBRVS Rate for Nonfacility Settings

When services are provided in nonfacility settings, the professional provider typically bears the costs of labor, medical supplies and medical equipment. These costs are included in the RBRVS rate for nonfacility settings.

Professional services will be paid at the RBRVS rate for nonfacility settings when the insurer doesn't make a separate payment to a facility. The following place of service codes will be paid at the rate for nonfacility settings:

Place of Service Code	Place of Service Description
01	Pharmacy
03	School
04	Homeless shelter
09	Correctional facility
11	Office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
16	Temporary lodging
17	Walk-in retail health clinic
20	Urgent care facility
32	Nursing facility
33	Custodial care facility
49	Independent clinic
50	Federally qualified health center
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment center
57	Nonresidential substance abuse treatment center
60	Mass immunization center
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Independent laboratory

When the insurer doesn't make a separate payment directly to the provider of the professional service, the facility will be paid for the service at the RBRVS rate for nonfacility settings. Remember to include a valid 2-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

EVALUATION AND MANAGEMENT SERVICES (E/M)

DOCUMENTATION AND BILLING

The history, examination and decision making are the key components in determining the level of E/M service to bill. Providers must use one of the following guidelines to determine the appropriate level of service.

The *1995 Documentation Guidelines for Evaluation & Management Services* available at *www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf*

or

The *1997 Documentation Guidelines for Evaluation and Management Services* available at *www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf*

Chart notes must contain documentation that justifies the level of service billed.

NEW AND ESTABLISHED PATIENT

L&I uses the CPT® definitions of new and established patients. If a patient presents with a work related condition and meets the definition in a provider's practice as

- A new patient, then a new patient E/M should be billed.
- An established patient, then an established patient E/M service should be billed, even if the provider is treating a new work related condition for the first time.

MEDICAL CARE IN THE HOME OR NURSING HOME

L&I allows attending providers to charge for E/M services in:

- Nursing facilities,
- Domiciliary, boarding home or custodial care settings and
- The home

The attending provider (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

PROLONGED EVALUATION AND MANAGEMENT

Payment of prolonged E/M is allowed with a maximum of 3 hours per day per patient. These services are payable only when another E/M code is billed on the same day using the following CMS payment criteria:

CPT® Code	Other CPT® Code(s) Required on Same Day
99354	99201-99205, 99212-99215, 99241-99245 or 99324-99350
99355	99354 and 1of the E/M codes required for 99354
99356	99221-99223, 99231-99233, 99251-99255, 99304-99310
99357	99356 and 1of the E/M codes required for 99356

The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the provider and the patient (whether the service was continuous or not). Prolonged physician services without direct contact are bundled and aren't payable in addition to other E/M codes. Refer to the above CMS websites for more information.

A report is required when billing for prolonged evaluation and management services. See Appendix G for additional information.

USING THE –25 MODIFIER

Modifier –25 must be appended to an E/M code when reported with another procedure on the same date of service. The E/M visit and the procedure must be documented separately.

Modifier –25 must be reported in the following circumstances to be paid:

- Same patient, same day encounter, and
- Same or separate visit, and
- Same provider, and
- Patient condition required a "significant separately identifiable E/M service above and beyond the usual pre and post care" related with the procedure or service.
- Scheduling back-to-back appointments doesn't meet the criteria for using the –25 modifier.

Example 1:

A worker goes to an osteopathic physician's office to be treated for back pain. The physician:

- Reviews the history,
- Conducts a review of body systems and
- Performs a clinical examination

The physician then advises the worker that osteopathic manipulation is a therapeutic option for treatment for the condition. The physician performs the manipulation during the office visit. This is a significant separately identifiable procedure performed at the time of the E/M service.

For this office visit, the physician may bill the appropriate:

- CPT® code for the manipulation and
- E/M code with the –25 modifier

Example 2:

A worker goes to a physician's office for a scheduled follow up visit for a work related injury. During the examination, the physician determines that the worker's condition requires a course of treatment that includes a trigger point injection at this time. The trigger point injection was not scheduled previously as part of the E/M visit.

The physician gives the injection during the visit. This is a significant separately identifiable procedure performed at the time of the E/M service. For the same time and date of service, the physician may bill the appropriate:

- CPT® code for the injection and
- E/M code with the –25 modifier

Example 3:

A worker arrives at a physician's office in the morning for a scheduled follow up visit for a work related injury. That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen.

The provider sees the patient for a second office visit. Since the 2 visits were completely separate, both E/M services may be billed.

- The scheduled visit would be billed with the E/M code alone and
- The unscheduled visit would be billed with the E/M code with the –25 modifier.

TREATING 2 SEPARATE CONDITIONS/SPLIT BILLING POLICY

If the worker is treated for 2 separate conditions at the same visit, the charge for the service must be divided equally between the payers. If evaluation and treatment of the 2 injuries increases the complexity of the visit, a higher level E/M code might be billed. If this is the case, CPT® guidelines must be followed and the documentation must support the level of service

billed. A physician would only be paid for more than 1 evaluation and management visit if there were 2 separate and distinct visits on the same day (see the Example 3 above). **Scheduling back-to-back appointments doesn't meet the criteria for using the –25 modifier.**

Separate chart notes and reports must be submitted when there are 2 different claims. The claims may be from injuries sustained while working for 2 different employers and the employers only have the right to information about injuries they are responsible for.

List all workers' compensation claims treated in Box 11 of the CMS-1500 form when submitting paper bills to L&I and in the remarks section when submitting electronic claims. L&I will divide charges equally to the claims.

If part of the visit is for a condition unrelated to an accepted L&I or self-insured claim and part is for the accepted condition, providers must apportion their usual and customary charges equally between L&I or the SIE and the other payer based on the level of service provided during the visit. In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer doesn't have the right to see information about an unrelated condition.

Example 1:

A worker goes to a provider to be treated for a work related shoulder injury and a separate work related knee injury. The provider treats both work related injuries. For State Fund claims, the provider bills L&I for 1 visit listing both workers' compensation claims in Box 11 of the CMS-1500 form. L&I will divide charges equally to the claims. For self-insured claims, contact the SIE or their TPA for billing instructions.

Example 2:

A worker goes to a provider's office to be treated for work related injury. During the examination, the worker mentions that he was in a car accident yesterday and now has neck pain. The provider treats the work related injury and the neck pain associated with the motor vehicle accident. The provider would bill 50% of his usual and customary fee to L&I or the SIE and 50% to the insurance company paying for the motor vehicle accident. L&I or self-insurer would only be responsible for the portion related to the accepted work related injury.

STANDBY SERVICES

The insurer pays for standby services when all the following criteria are met:

- Another provider requested the standby service; and
- The standby service involves prolonged provider attendance without direct face-to-face patient contact; and
- The standby provider isn't concurrently providing care or service to other patients during this period; and
- The standby service doesn't result in the standby provider's performance of a procedure subject to a "surgical package" and
- Standby services of 30 minutes or more are provided.

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported. Round all fractions of a 30 minute period downward. A report is required when billing for standby services.

CASE MANAGEMENT SERVICES

Team Conferences

Team conferences may be payable when the attending provider, consultant or psychologist meets with one or more of the following:

- An interdisciplinary team of health professionals
- L&I staff
- Vocational rehabilitation counselors
- Nurse case managers
- L&I medical consultants
- SIEs/TPAs
- Physical and occupational therapists and speech-language pathologists

Billing codes

Patient status	CPT® code (Physicians)	CPT® code (Nonphysicians)
Patient present	Appropriate level E&M	99366
Patient not present	99367	99368

Multiple units of 99366, 99367 and 99368 may be billed for conferences exceeding 30 minutes:

Duration of conference	Units billed
Up to 30 minutes	1 unit
Up to 60 minutes	2 units

Physical and Occupational Therapists

Physical and occupational therapists and speech-language pathologists may be paid for attendance at a team conference only when the Medical Director/Associate Medical Director at L&I or the SIE/TPA authorizes the conference in advance.

To be authorized all of the following criteria must be met:

- There is a moderate to high probability of severe, prolonged functional impairment. This may be addressed with the development of a multidisciplinary approach to the plan of care; and
- The need for a conference exceeds the expected routine correspondence/communication among healthcare/vocational providers; and
- The worker isn't participating in a program in which payment for conference is already included in the program payment (For example, head injury program, pain clinic, work hardening); and
- 3 or more disciplines/specialties need to participate, including PT, OT or Speech.

To be paid for the conference the therapists must:

- Bill using CPT® code 99366 if the patient is present or 99368 if the patient isn't present.
- Bill on a CMS-1500 form
- Submit a separate report of the conference; joint reports aren't allowed. The conference report must include:
- Evaluation of the effectiveness of the previous therapy plan; and
- New goal-oriented, time-limited treatment plan or
- Objective measures of function that address the return to work process; and
- The duration of the conference

NOTE: Providers in a hospital setting may only be paid if the services are billed on a CMS-1500 with an individual provider account number.

Telephone Calls

Telephone calls are payable to the attending provider, consultant, psychologist or other provider only when they personally participate in the call. These services are payable when discussing or coordinating care or treatment with:

- The worker
- L&I staff
- Vocational rehabilitation counselors
- Nurse case managers
- Health services coordinators (COHE)
- L&I medical consultants
- Other physicians
- Other providers
- TPAs
- Employers

The insurer will pay for telephone calls if the provider leaves a detailed message for the recipient and meets all of the documentation requirements.

NOTE: L&I doesn't adhere to the CPT® limits for telephone calls

Telephone calls **are payable** regardless of when the previous or next office visit occurs.

ARNPs, PAs, psychologists, PTs and OTs must bill using nonphysician codes.

Telephone calls for authorization, resolution of billing issues or ordering prescriptions **aren't payable.**

Duration	CPT® code (Physicians)	CPT® code (Nonphysicians)
1-10 minutes	99441	98966
11-20 minutes	99442	98967
21-30 minutes	99443	98968

Documentation Requirements

Documentation for case management services (team conferences and telephone calls) must include:

- The date, and
- The participants and their titles, and
- The length of the call or visit, and
- The nature of the call or visit, and
- All medical, vocational or return to work decisions made.

Psychiatrists and clinical psychologists may only bill for these services when also providing consultation or evaluation.

Team conference documentation must also include a goal-oriented, time-limited treatment plan covering:

- Medical,
- Surgical,
- Vocational or return to work activities, or
- Objective measures of function

The treatment plan must allow a determination whether a previously created plan is effective in returning the worker to an appropriate level of function.

Online Communications and Consultations

Electronic online communications (e-mail) with the worker are payable only when personally made by the attending provider, consultant, psychologist or physical or occupational therapist who has an existing relationship with the worker.

Online communications must be conducted over a secure network, developed and implemented using guidelines from reputable industry sources such as those published by:

- The American Medical Association
- The Federation of State Medical Boards
- The eRisk Working Group for Healthcare

Services payable for communications with workers include:

- Follow up care resulting from a face-to-face visit that doesn't require a return to the office.
- Non-urgent consultations regarding an accepted condition when the equivalent service provided in person would have resulted in a charge.
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications.
- Discussions of return-to-work activities with workers and employers.

Services not payable include:

- Routine requests for appointments.
- Test results that are informational only.
- Requests for prescription refills.
- Consultations that result in an office visit.

Electronic communications are also payable when discussing or coordinating care, treatment or return-to-work activities with:

- L&I staff
- Vocational rehabilitation counselors
- Case managers
- L&I medical consultants
- TPAs
- Employers

Documentation Requirements

Documentation for electronic communications must include:

- The date, and
- The participants and their titles, and
- The nature of the communication, and
- All medical, vocational or return to work decisions made.

Provider and CPT® code	Nonfacility fee	Facility fee
Physician - 99444	$43.17	$40.95
Nonphysician - 98969	$43.17	$40.95

CARE PLAN OVERSIGHT

The insurer allows separate payment for care plan oversight services (CPT® codes 99375, 99378 and 99380). Payment is limited to 1 per attending provider, per patient, per 30 day period. Care plan services (CPT® codes 99374, 99377 and 99379) of less than 30 minutes within a 30 day period are considered part of E/M services and **aren't** separately payable.

Payment for care plan oversight to a provider providing post surgical care during the postoperative period will be made only:

- If the care plan oversight is documented as unrelated to the surgery and
- Modifier –24 is used.

The attending provider (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

TELECONSULTATIONS AND OTHER TELEHEALTH SERVICES

L&I adopted a modified version of CMS's policy on teleconsultations and other telehealth services. Telehealth services and teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real-time consultation between the patient and consultant.

Coverage of Teleconsultations

Teleconsultations **are covered** in the same manner as face-to-face consultations (refer to WACs 296-20-045 and –051), but in addition, **all** of the following conditions must be met:

- The **consultant** must be a doctor as described in WAC 296-20-01002 or a PhD Clinical Psychologist. A consulting DC must be an approved consultant with L&I; and
- The **referring provider** must be 1 of the following: MD, DO, ND, DPM, OD, DMD, DDS, DC, ARNP, PA or PhD Clinical Psychologist; and
- The patient must be present at the time of the consultation; and
- The exam of the patient must be under the control of the consultant; and
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the consultant; and
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer; and
- A referring provider who isn't the attending must consult with the attending provider before making the referral.

Coverage of other Telehealth Services

Other procedures and office visits that are covered include:

- Follow up visits after the initial consultation
- Psychiatric intake and evaluation
- Individual psychotherapy
- Pharmacologic management
- End stage renal disease (ESRD) services
- Team conferences

Payment of Teleconsultations and other Telehealth Services

Providers

Teleconsultations and telehealth services are paid in the same manner as face-to-face visits. The insurers will pay according to the following criteria:

- Providers must append a **GT** modifier to 1 of the appropriate services listed in the table below.
- No separate payment will be made for the review and interpretation of the patient's medical records and/or the required report that must be submitted to the referring provider and to the insurer.

Providers may bill these services:
Consultation codes
Office or other outpatient visits
Psychiatric intake and assessment
Individual psychotherapy
Pharmacologic management
End stage renal disease (ESRD) services
Team conferences

Originating Facility

The insurer will pay an originating site facility fee for the use of the telecommunications equipment. Bill for these services with HCPCS code:

Q3014 ..... $34.19

The insurer will only pay for a professional service by the referring provider if it is a separately identifiable service provided on the same day as the telehealth service.

Documentation for both must be clearly and separately identified in the medical record.

Telemedicine Services Not Covered

Procedures and services **not covered** include:

- "Store and Forward" technology, asynchronous transmission of medical information to be reviewed by the consultant at a later time.
- Facsimile transmissions.
- Installation or maintenance of telecommunication equipment or systems.
- Home health monitoring.
- Telehealth transmission, per minute (HCPCS code T1014).

END STAGE RENAL DISEASE (ESRD)

L&I follows CMS's policy regarding the use of E/M services along with dialysis services. E/M services (CPT® codes 99231-99233 and 99307-99310) **aren't payable** on the same date as hospital inpatient dialysis (CPT® codes 90935, 90937, 90945 and 90947). These E/M services are bundled in the dialysis service.

Separate billing and payment will be allowed when billed on the same date as an inpatient dialysis service for:

- An initial hospital visit (CPT® codes 99221-99223),
- An initial inpatient consultation (CPT® codes 99251-99255) and
- A hospital discharge service (CPT® code 99238 or 99239)

SURGERY SERVICES

GLOBAL SURGERY POLICY

Many surgeries have a follow-up period during which charges for normal postoperative care are bundled into the global surgery fee. The global surgery follow-up period for each surgery is listed in the Fol-Up column in the Professional Services Fee Schedule.

Services and Supplies Included in the Global Surgery Policy

The following services and supplies are included in the global surgery follow-up period and are considered bundled into the surgical fee:

- The operation itself.
- Preoperative visits, in or out of the hospital, beginning on the day before the surgery.
- Services by the primary surgeon, in or out of the hospital, during the postoperative period.
- The following services:
  - Dressing changes;
  - Local incisional care and removal of operative packs;
  - Removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints;
  - Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes;
  - Change and removal of tracheostomy tubes; and
  - Cast room charges.
- Additional medical or surgical services required because of complications that don't require additional operating room procedures.

NOTE: Casting materials **aren't** part of the global surgery policy and are paid separately.

How to Apply the Follow-Up Period

The follow-up period applies to **any provider** who participated in the surgical procedure. These providers include:

- Surgeon or physician who performed any component of the surgery (The pre, intra, and/or postoperative care of the patient; identified by modifiers –56, –54 and –55)
- Assistant surgeon (identified by modifiers –80, –81 and –82)
- 2 surgeons (identified by modifier –62)
- Team surgeons (identified by modifier –66)
- Anesthesiologists and CRNAs

The follow-up period always applies to the following CPT® codes, unless modifier –22, –24, –25, –57, –58, –78 or –79 is appropriately used:

E/M Codes		Ophthalmological Codes
99211-99215	99304-99310	92012-92014
99218-99220	99315-99318	
99231-99239	99334-99337	
99291-99292	99347-99350	

Professional inpatient services (CPT® codes 99211-99223) are only payable during the follow-up period if they are performed on an emergency basis (for example, they aren't payable for scheduled hospital admissions).

Codes that are considered bundled **aren't payable** during the global surgery follow-up period.

Services and Supplies Not Included in the Global Surgery Policy

- The initial consultation or evaluation by the surgeon to determine the need for surgery.
- Services of other providers except where the surgeon and the other provider(s) agree on the transfer of care.
- Visits unrelated to the diagnosis of the surgical procedure performed, unless the visits occur due to surgery complications.
- Treatment for the underlying condition or an added course of treatment which isn't part of the normal surgical recovery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Distinct surgical procedures during the postoperative period which aren't re-operations or treatment for complications (A new postoperative period begins with the subsequent procedure.)
- Treatment for postoperative complications which requires a return trip to the operating room.
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Immunotherapy management for organ transplants.
- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the provider.

PRE, INTRA OR POSTOPERATIVE SERVICES

The insurer will allow separate payment when different providers perform the preoperative, intraoperative or postoperative components of the surgery. The modifiers (–54, –55 or –56) must be used. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

If different providers perform different components of the surgery (pre, intra or postoperative care), the global surgery policy applies to each provider. For example, if the surgeon performing the operation transfers the patient to another provider for the postoperative care, the same global surgery policy, including the restrictions in the follow-up day period, applies to both providers.

MINOR SURGICAL PROCEDURES

For minor surgical procedures, the insurer only allows payment for an E/M office visit during the global period when:

- A documented, unrelated service is furnished during the postoperative period and modifier –24 is used, or
- The provider who performs the procedure is seeing the patient for the first time an initial new patient E/M service can be billed. This is considered a significant, separately identifiable service and modifier –25 must be used. Appropriate documentation must be made in the chart describing the E/M service.

Modifier –57, decision for surgery, isn't payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation isn't paid in addition to the procedure.

Modifier –57 is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

STANDARD MULTIPLE SURGERY POLICY

When multiple surgeries are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

- **100%** of the global fee for the procedure or procedure group with the highest value, according to the fee schedule.
- **50%** of the global fee for the **second through fifth procedures** with the next highest values, according to the fee schedule.

More than 5 procedures require documentation and individual review to determine payment amount.

When different types of surgical procedures are performed on the patient on the same day, the payment policies will always be applied in the following sequence:

- Multiple endoscopy procedures.
- Other modifier policies.
- Standard multiple surgery policy.

When the same surgical procedure is performed on multiple levels, each level must be billed as a separate line item. See the Bilateral Procedures Policy for additional instructions on billing bilateral procedures.

BILATERAL PROCEDURES POLICY

Bilateral surgeries should be billed as 2 line items. Modifier –50 must be applied to the second line item. The second line item is paid at the lesser of the billed charge or 50% of the fee schedule maximum. Bilateral procedures are considered 1 procedure when determining the highest valued procedure before applying multiple surgery rules.

Check the Professional Services Fee Schedule to see if modifier –50 is valid with the procedure performed.

Example: Bilateral Procedure

Line Item	CPT® Code/Modifier	Maximum Payment (nonfacility setting)	Bilateral Policy Applied	Allowed Amount
1	64721	$678.47		$678.47 (1)
2	64721-50	$678.47	$339.24 (2)	$339.24
			Total Allowed Amount in Nonfacility Setting:	$1017.71 (3)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.
(2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
(3) Represents total allowable amount.

Example: Bilateral Procedure and Multiple Procedures

Line Item	CPT® Code/Mod	Max Payment (nonfac setting)	Bilateral Applied	Multiple Applied	Allowed Amount
1	63042	$2,068.61			$2,068.61 (1)
2	63042-50	$2,068.61	$1,034.31 (2)		$1,034.31
					subtotal $3,102.92 (3)
3	22612-51	$2,543.98		$1,271.99(4)	$1,271.99
Total Allowed Amount in Nonfacility Setting:					$4,374.91 (5)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.
(2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
(3) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.
(4) The third line item billed with modifier –51 is paid at 50% of the maximum payment.
(5) Represents total allowable amount.

ENDOSCOPY PROCEDURES POLICY

For the purpose of these payment policies, endoscopy will be used to refer to any invasive procedure performed with the use of a fiberoptic scope or other similar instrument.

Payment isn't allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier –25 is used.

Endoscopy procedures are grouped into clinically related families. Each endoscopy family contains a base procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an endoscopy family is listed in the Endo Base column in the Professional Services Fee Schedule. Base procedures and their family members are also identified in **Appendix A**, Endoscopy Families.

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

1. The endoscopy procedure with the highest dollar value is 100% of the fee schedule value.
2. For subsequent endoscopy procedures, payment is the difference between the family member and the base fee.
3. When the fee for the family member is less than the base fee, the payment is $0.00 (see Example 2).
4. No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an endoscopic group. If more than 1 endoscopic group or other nonendoscopy procedure is billed for the same patient on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see Examples 3 and 4).

Multiple endoscopies that aren't related (Each is a separate and unrelated procedure) are priced as follows:

1. 100% for each unrelated procedure, then
2. Apply the standard multiple surgery policy

Example 1: 2 Endoscopy Procedures in the Same Family

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	29805	$ 751.52	$ 000.00 (2)	
1	29822	$ 918.64	$ 167.12 (4)	$ 167.12 (5)
2	29826	$ 1,068.06	$ 1,068.06 (3)	$ 1,068.06 (5)
			Total Allowed Amount in Nonfacility Setting:	$ 1,235.18 (6)

(1) Base code listed is for reference only (not included on bill form).
(2) Payment isn't allowed for a base code when a family member is billed.
(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
(4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
(5) Amount allowed under the endoscopy policy.
(6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy doesn't apply because only 1 family of endoscopic procedures was billed.

Example 2: Endoscopy Family Member with Fee Less than Base Procedure

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	43235	$488.65		
1	43241	$ 253.22	$ 000.00 (2)	
2	43251	$ 359.16	$ 359.16 (3)	$ 359.16 (4)
			Total Allowed Amount in Nonfacility Setting:	$ 359.16 (5)

(1) Base code listed is for reference only (not included on bill form).
(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
(3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.
(4) Allowed amount under the endoscopy policy.
(5) Represents total allowed amount. Standard multiple surgery policy doesn't apply because only 1 endoscopic group was billed.

Example 3: 2 Surgical Procedures Billed with an Endoscopic Group (highest fee)

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	11402	$ 260.65		$ 130.33 (5)
2	11406	$ 481.46		$ 240.73 (5)
Base (1)	29830	$ 724.95		
3	29835	$ 808.52	$ 83.57 (3)	$ 83.57 (4)
4	29838	$ 946.87	$ 946.87 (2)	$ 946.87 (4)
			Total Allowed Amount in Nonfacility Setting:	$ 1401.50 (6)

(1) Base code listed is for reference only (not included on bill form).
(2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.
(3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100%.
(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
(6) Represents total allowed amount after applying all applicable global surgery policies.

Example 4: 1 Surgical Procedure (highest fee) Billed with an Endoscopic Group

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	23412	$ 1,370.22		$ 1,370.22 (4)
Base (1)	29805	$ 751.52		
3	29826	$ 1,068.06	$ 316.54 (3)	$ 158.27 (5)
4	29824	$ 1,078.02	$1,078.02 (2)	$ 539.01 (5)
			Total Allowed Amount in Nonfacility Setting:	$ 2,067.50 (6)

(1) Base code listed is for reference only (not included on bill form).
(2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.
(3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100%.
(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
(6) Represents total allowed amount after applying all applicable global surgery policies.

MICROSURGERY

CPT® code 69990 is an add-on surgical code that indicates an operative microscope has been used. As an add-on code, it isn't subject to multiple surgery rules.

CPT® code 69990 isn't payable when:

- Using magnifying loupes or other corrected vision devices, or
- Use of the operative microscope is an inclusive component of the procedure, (for example the procedure description specifies that microsurgical techniques are used), or
- Another code describes the same procedure being done with an operative microscope. For example, CPT® code 69990 can't be billed with CPT® code 31535 because CPT® code 31536 describes the same procedure using an operating microscope. The table below contains a complete list of all such codes.

CPT® Codes Not Allowed with CPT® 69990

CPT®Code	CPT®Code	CPT®Code	CPT®Code
15756-15758	26551-26554	31561	63075-63078
15842	26556	31571	64727
19364	31526	43116	64820-64823
19368	31531	43496	65091-68850
20955-20962	31536	49906	
20969-20973	31541-31546	61548	

SPINAL INJECTION POLICY

Injection procedures are divided into 4 categories; injection procedures that:

1. Require fluoroscopy.
2. Injections that include fluoroscopy or CT guidance in their descriptions.
3. May be done without fluoroscopy when performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. These procedures require fluoroscopy if they aren't performed at a certified or accredited facility.
4. Don't require fluoroscopy.

Definition of Certified or Accredited Facility

L&I defines a certified or accredited facility as a facility or office that has certification or accreditation from 1 of the following organizations:

1. Medicare (CMS - Centers for Medicare and Medicaid Services)
2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
3. Accreditation Association for Ambulatory Health Care (AAAHC)
4. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
5. American Osteopathic Association (AOA)
6. Commission on Accreditation of Rehabilitation Facilities (CARF)

Spinal Injection Procedures that Require Fluoroscopy

CPT® Code	CPT® Fluoroscopy Codes(1),(2)
62268	77002, 77012, 76942
62269	77002, 77012, 76942
62281	77003, 72275
62282	77003, 72275
62284	77003, 77012, 76942, 72240, 72255, 72265, 72270
62290	72295
62291	72285
62292	72295
62294	77002, 77003, 77012, 75705
62310	77003, 72275
62311	77003, 72275
62318	77003, 72275
62319	77003, 72275

(1) One of these fluoroscopy codes must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied.

(2) Only 1 of these codes may be billed for each injection.

Spinal Injection Procedures that Include Fluoroscopy, Ultrasound or CT in the Description

Paravertebral facet joint injections now include fluoroscopic or CT guidance as part of the description. Fluoroscopic, ultrasound or CT guidance can't be billed separately.

CPT® Code	CPT® Code
64479	0213T
64480	0214T
64483	0215T
64484	0216T
64490	0217T
64491	0218T
64492	0228T
64493	0229T
64494	0230T
64495	0231T

Spinal Injection Procedures that May Be Done Without Fluoroscopy

Interlaminar epidural steroid injections may be performed without fluoroscopy if performed at a certified or accredited facility by a provider with privileges to perform the procedure at that facility. The provider must decide whether to use fluoroscopy based on sound medical practice.

To be payable, these spinal injections must include a facility place of service code and documentation that the procedure was performed at a certified or accredited facility.

CPT® Code
62310
62311
62318
62319

Spinal Injection Procedures that Don't Require Fluoroscopy

CPT® Code
62270
62272
62273

Payment Methods for Spinal Injection Procedures

Provider Type	Procedure Type	Payment Method
Physician or CRNA/ARNP	Injection(3)	–26 Component of Professional Services Fee Schedule
	Radiology	–26 Component of Professional Services Fee Schedule
Radiology Facility	Injection	No Facility Payment
	Radiology	–TC Component of Professional Services Fee Schedule
Hospital(1)	Injection	APC or POAC
	Radiology(2)	APC or –TC Component of Professional Services Fee Schedule
ASC	Injection	ASC Fee Schedule
	Radiology	–TC Component is a bundled service

(1) Payment method depends on a hospital's classification.
(2) Radiology codes may be packaged with the injection procedure.
(3) A separate payment for the injection **won't be made** when computed tomography is used for imaging unless documentation demonstrating medical necessity is provided.

REGISTERED NURSES AS SURGICAL ASSISTANTS

Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to L&I along with their completed provider application.

1. A photocopy of her/his valid and current registered nurse license, and
2. A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is 90% of the allowed fee that would be paid to an assistant surgeon.

PROCEDURES PERFORMED IN A PHYSICIAN'S OFFICE

Procedures performed in a provider's office are paid at nonfacility rates that include office expenses. Modifier –SU denotes the use of facility and equipment while performing a procedure in a provider's office. Services billed with an –SU modifier aren't covered.

Providers' offices must meet ASC requirements to qualify for separate facility payments. Refer to Chapter 296-23B WAC for information about the requirements.

MISCELLANEOUS

Angioscopy

Payment for angioscopies CPT® code 35400 is limited to only 1 unit based on its complete code description encompassing multiple vessels. The work involved with varying numbers of vessels was incorporated in the RVUs.

Autologous Chondrocyte Implant

The insurer **may cover** autologous chondrocyte implant (ACI) when all of the guidelines are met. ACI requires **prior authorization**.

In addition to the clinical guidelines for the procedure, the surgeon must:

- Have received training through Genzyme Biosurgery and
- Have performed or assisted with 5 ACI procedures or
- Perform ACI under the direct supervision and control of a surgeon who has performed 5 or more ACI procedures.

The appropriate CPT® code for the implant is 27412. Use CPT® code 29870 for harvesting the chondrocytes.

If the procedure is authorized, the insurer will pay US Bioservices for Carticel® (autologous cultured chondrocytes). For more information, go to http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/autologouschondrocyteimplant.asp

Bone Morphogenic Protein

The insurer **may cover** the use of bone morphogenic protein as an alternative to autograft in recalcitrant long bone nonunion where use of autograft isn't feasible and alternative treatments have failed. It may also cover its use for spinal fusions in patients with degenerative disc disease at 1 level from L4-S1.

CPT® codes used depend on the specific procedure being performed.

All of the criteria and guidelines must be met before the insurer will authorize the procedures. For more information, go to http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonemorphogenics.asp. In addition, lumbar fusion guidelines must be met. For more information, go to http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/TreatGuide/default.asp

Bone Growth Stimulators

The insurer, with **prior authorization**, pays for bone growth stimulators for specific conditions when proper and necessary, including:

- Noninvasive or external stimulators including those that create a small electrical current and those that deliver a low intensity ultrasonic wave to the fracture, and
- Implanted electrical stimulators that supply a direct current to the bone.

For more information, go to

http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/bonegrowthstimulators.asp

Billing Codes for Bone Growth Stimulators

Billing Code	Description	Prior Auth.
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal application	Required
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal application	Required
E0749	Osteogenesis stimulator, electrical (surgically implanted)	Required
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive	Required

Botulinum Toxin

The insurer covers botulinum toxin injections (Botox®: BTX-A, Myobloc®: BTX-B) **with prior authorization** for the following indications when it is proper and necessary:

- Blepharospasm
- Primary axillary hyperhidrosis
- Cervical dystonia (spasmodic torticollis)
- Strabismus
- Hemifacial spasm
- Torsion dystonia (idiopathic/symptomatic)
- Laryngeal or spasmodic dysphonia
- Torticollis, unspecified
- Orofacial dyskinesia
- Writer's cramp
- Oromandibular dystonia

Patients must have failed conservative treatment such as other medications and physical therapy before Botox will be authorized.

Noncovered Indications

The insurer won't authorize payment for BTX injections for other off-label indications.

Criteria for Additional Injections

The insurer may authorize 1 subsequent injection session administered 90 days after the initial session if the first BTX session produced an adequate, functional response. Providers must submit documents describing the patient's response to BTX following a session of injections. No more than 2 injections per individual will be authorized due to risk of antibody development and decrease in response.

For more information, go to

http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/botulinumtoxin.asp

Closure of Enterostomy

Closures of enterostomy **aren't payable** with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy. CPT® code 44139 will be denied if it is billed with CPT® code 44625 or 44626.

Epidural Adhesiolysis

The insurer, with **prior authorization**, pays for epidural adhesiolysis using the 1 day protocol but doesn't pay for the 3 day protocol. Epidural adhesiolysis is also known as percutaneous lysis of epidural adhesions, epidural decompressive neuroplasty, and Racz neurolysis. Workers must meet the following criteria:

- The worker has experienced acute low back pain or acute exacerbation of chronic low back pain of no more than 6 months duration.
- The provider intends to conduct the adhesiolysis in order to administer drugs closer to a nerve.
- The provider documents strong suspicion of adhesions blocking access to the nerve.
- Adhesions blocking access to the nerve have been identified by Gallium MRI or Fluoroscopy during epidural steroid injections.

For more information, go to
http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Epiduraladhesiolysis.asp

Meniscal Allograft Transplantation

The insurer, with **prior authorization**, may cover meniscal allograft transplantation when all of the guidelines are met.

In addition to the clinical guidelines for the procedure, the surgeon must:

- Have performed or assisted with 5 meniscal allograft transplants or
- Perform the transplant under the direct supervision and control of a surgeon who has performed 5 or more transplants.

For more information, go to

http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/CovMedDev/SpecCovDec/Meniscal.asp

ANESTHESIA SERVICES

Anesthesia payment policies are established by L&I with input from the Reimbursement Steering Committee (RSC) and the Anesthesia Technical Advisory Group (ATAG). The RSC is a standing committee with representatives from L&I, DSHS and HCA. The ATAG includes anesthesiologists, CRNAs and billing professionals.

NONCOVERED AND BUNDLED SERVICES

Anesthesia Assistant Services

The insurer doesn't cover anesthesia assistant services.

Noncovered Procedures

Anesthesia isn't payable for procedures that **aren't covered** by L&I. Refer to **Appendix D** for a list of noncovered procedures.

Patient Acuity

Patient acuity doesn't affect payment levels. Payment for CPT® codes 99100, 99116, 99135 and 99140 is considered bundled and isn't payable separately. CPT® physical status modifiers (–P1 to –P6) and CPT® 5-digit modifiers aren't accepted.

Payment for Anesthesia

Payment for anesthesia services will only be made to anesthesiologists and certified registered nurse anesthetists.

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure. Services billed with modifier –47 (anesthesia by surgeon) are considered bundled and aren't payable separately.

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

CRNA services are paid at a maximum of 90% of the allowed fee that would be paid to a physician.

Refer to WAC 296-23-240 for licensed nursing rules and 296-23-245 for licensed nursing billing instructions. For more detailed billing instructions, including examples of how to submit bills, refer to L&I's CMS-1500 billing instructions (publication F248-094-000).

Billing Tip

CRNA services shouldn't be reported on the same CMS-1500 form used to report anesthesiologist services; this applies to solo CRNA services as well as team care.

MEDICAL DIRECTION OF ANESTHESIA (TEAM CARE)

L&I follows CMS's policy for medical direction of anesthesia (team care).

Requirements for Medical Direction of Anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a preanesthetic examination and evaluation, and
- Prescribe the anesthesia plan, and
- Participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence, and
- Make sure any procedures in the anesthesia plan that he/she doesn't perform are performed by a qualified individual as defined in program operating instructions, and
- Monitor the course of anesthesia administration at frequent intervals, and
- Remain physically present and available for immediate diagnosis and treatment of emergencies, and
- Provide indicated postanesthesia care.

In addition, physicians directing anesthesia:

- May direct no more than 4 anesthesia services concurrently, and
- Can't perform any other services while directing the single or concurrent services.

The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

Documentation Requirements for Team Care

The physician must document in the patient's medical record that the medical direction requirements were met. The physician doesn't submit documentation with the bill, but must make it available to the insurer upon request.

Billing for Team Care

When billing for team care situations:

- Anesthesiologists and CRNAs must report their services on separate CMS-1500 forms using their own provider account numbers.
- Anesthesiologists must use the appropriate modifier for medical direction or supervision (–QK or –QY).
- CRNAs should use modifier –QX.

Payment for Team Care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services.
  (Refer to Anesthesia Payment Calculation in the Anesthesia Services Paid with Base and Time Units section, page **60**)
- The maximum payment to the physician is 50% of the maximum payment for solo physician services.
- The maximum payment to the CRNA is 45% of the maximum payment for solo physician services (90% of the other 50% share).

Anesthesia Teaching Physicians

Teaching physicians may be paid at the personally performed rate when the physician is involved in the training of physician residents in:

- A single anesthesia case, or
- Two concurrent anesthesia cases involving residents, or
- A single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules.

ANESTHESIA SERVICES PAID WITH BASE AND TIME UNITS

Most anesthesia services are paid with base and time units. These services should be billed with CPT® anesthesia codes 00100 through 01999 and the appropriate anesthesia modifier.

Anesthesia Base Units

Most of L&I's anesthesia base units are the same as the units adopted by CMS. L&I differs from the CMS base units for some procedure codes based on input from the ATAG. The anesthesia codes, base units and base sources are listed in the Professional Services Fee Schedule.

Anesthesia Time

Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent).

Anesthesia time ends when the anesthesiologist or CRNA is no longer in constant attendance (when the patient can be safely placed under postoperative supervision). Anesthesia must be billed in one-minute time units.

List only the time in minutes on your bill. Don't include the base units. They are automatically added by L&I's payment system.

Anesthesia Modifiers

Anesthesiologists and CRNAs should use the modifiers in this section when billing for anesthesia services paid with base and time units. Except for modifier –99, these modifiers aren't valid for anesthesia services paid by the RBRVS method.

Services billed with CPT® 5-digit modifiers and physical status modifiers (P1 through P6) **aren't** paid. Refer to a current CPT® or HCPCS book for complete modifier descriptions and instructions.

CPT® Modifier

For Use By	Modifier	Brief Description	Notes
Anesthesiologists and CRNAs	–99	Multiple modifiers	Use this modifier when 5 or more modifiers are required. Enter –99 in the modifier column on the bill. List individual descriptive modifiers elsewhere on the billing document.

HCPCS Modifiers

For Use By	Modifier	Brief Description	Notes
Anesthesiologists	–AA	Anesthesia services performed personally by anesthesiologist	
	–QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual	Payment based on policies for team services.
	–QY	Medical direction of 1 CRNA for a single anesthesia procedure	Payment based on policies for team services.
CRNAs*	–QX	CRNA service: with medical direction by a physician	Payment based on policies for team services.
	–QZ	CRNA service: without medical direction by a physician(1)	Maximum payment is 90% of the maximum allowed for physician services.

(1) Bills from CRNAs that don't contain a modifier are paid based on payment policies for team services.

Anesthesia Payment Calculation

The maximum payment for anesthesia services paid with base and time units is calculated using the

- Base value for the procedure,
- Time the anesthesia service is administered and
- L&I's anesthesia conversion factor.

The anesthesia conversion factor is published in WAC 296-20-135. For services provided on or after July 1, 2010, the anesthesia conversion factor is $47.85 per 15 minutes ($3.19 per minute). Providers are paid the lesser of their charged amount or L&I's maximum allowed amount.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by 15.
2. Add the value from step 1 to the total number of whole minutes.
3. Multiply the result from step 2 by $3.19.

The maximum payment for services provided by a CRNA is 90% of the maximum payment for a physician.

Example: CPT® code 01382 (anesthesia for knee arthroscopy) has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

1. Base units x 15 = 3 x 15 = 45 base units,
2. 45 base units + 60 time units (minutes) = 105 base and time units,
3. Maximum payment for physicians = 105 x $3.19 = $334.95

ANESTHESIA ADD-ON CODES

Anesthesia add-on codes must be billed with a primary anesthesia code. There are 3 anesthesia add-on CPT® codes: 01953, 01968 and 01969.

- Add-on code 01953 should be billed with primary code 01952.
- Add-on codes 01968 and 01969 should be billed with primary code 01967.
- Add-on codes 01968 and 01969 should be billed in the same manner as other anesthesia codes paid with base and time units.

Providers should report the total time for the add-on procedure (in minutes) in the Units column (Field 24G) of the CMS-1500 form.

Anesthesia for Burn Excisions or Debridement

The anesthesia add-on code for burn excision or debridement, CPT® code 01953, must be billed according to the instructions in the following table.

Total Body Surface Area	Primary Code	Units of Add-On Code 01953
Less than 4 percent	01951	None
5 - 9 percent	01952	None
Up to 18 percent	01952	1
Up to 27 percent	01952	2
Up to 36 percent	01952	3
Up to 45 percent	01952	4
Up to 54 percent	01952	5
Up to 63 percent	01952	6
Up to 72 percent	01952	7
Up to 81 percent	01952	8
Up to 90 percent	01952	9
Up to 99 percent	01952	10

ANESTHESIA SERVICES PAID BY THE RBRVS METHOD

Some services commonly performed by anesthesiologists and CRNAs aren't paid with anesthesia base and time units. These services include:

- Anesthesia evaluation and management services,
- Most pain management services and
- Other selected services.

Modifiers

Anesthesia modifiers –AA, –QK, –QX, –QY and –QZ aren't valid for services paid by the RBRVS method.

Refer to a current CPT® or HCPCS book for a complete list of modifiers and descriptions. Refer to **Appendix E** for a list of modifiers that affect payment.

Maximum Payment

Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule.

Billing Tip

When billing for services paid with the RBRVS method, enter the total **number of times the procedure is performed** in the Units column (Field 24G on the CMS-1500 bill form).

E/M Services Payable with Pain Management Procedures

An E/M service is payable on the same day as a pain management procedure only when:

- It is the patient's initial visit to the provider who is performing the procedure, or
- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service. (see Using the -25 modifier)

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action. The use of E/M codes on days after the procedure is performed is subject to the global surgery policy (refer to the Surgery Services section).

Injection Code Treatment Limits

Details regarding treatment guidelines and limits for the following kinds of injections can also be found in WAC 296-20-03001. Refer to Medication Administration in the Other Medicine Services section; page **91** for information on billing for medications.

Injection	Treatment Limit
Epidural and caudal injections of substances other than anesthetic or contrast solution	**Maximum of 6** injections per acute episode are allowed.
Facet injections	**Maximum of 4** injection procedures per patient are allowed.
Intramuscular and trigger point injections of steroids and other nonscheduled medications and trigger point dry needling(1)	**Maximum of 6** injections per patient are allowed.

(1) Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. L&I doesn't cover acupuncture services (WAC 296-20-03002). Dry needling of trigger points should be billed using trigger point injection codes. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001 (14).

RADIOLOGY

X-RAY SERVICES

Requirements and Definitions

Attending health care providers who produce or order diagnostic imaging studies are responsible for determining the necessity for the study and must briefly document that justification in their chart notes. Examples include:

- Plain films of the cervical spine to include obliques to rule out foraminal encroachment as possible cause for radiating arm pain.
- PA and lateral chest films to determine cause for dyspnea.

All imaging studies must be of adequate technical quality to rule out radiologically-detectable pathology

Global radiology services include both a technical component (producing the study) and a professional component (interpreting the study).

If only the technical component of a radiology service is performed, the modifier -TC must be used, and only the technical component fees are allowable.

If only the professional component of a radiology service is performed, the modifier -26 must be used, and only the professional component fees are allowable.

Repeat X-rays

The insurer **won't pay** for excessive or unnecessary X-rays. Repeat or serial X-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s). Documented changes in objective findings or subjective complaints must support the need.

Number of Views

There isn't a specific code for additional views for radiology services. Therefore, the number of X-ray views that may be paid is determined by the CPT® description for that service.

For example, the following CPT® codes for radiologic exams of the spine are payable as outlined below:

CPT® Code	Payable
72020	Once for a single view
72040	Once for 2 to 3 cervical views
72050	Once for 4 or more cervical views
72052	Once, regardless of the number of cervical views it takes to complete the series

Incomplete Full Spine Studies

A full spine study is a radiologic exam of the entire spine; anteroposterior (AP) and lateral views. Depending on the size of the film and the size of the patient, the study may require up to 6 films (the AP and lateral views of the cervical, thoracic and lumbar spine). An incomplete full spine study is one in which the entire AP or lateral view is taken, but not both. For example, a study is performed in which all AP and lateral views are obtained except for the lateral thoracic. Incomplete full spine studies in which 5 views are obtained are payable at the maximum fee schedule amount for CPT® code 72010. Incomplete full spine studies in which 4 views are taken are payable at one-half the maximum fee schedule amount for CPT® code 72010 and must be billed with a –52 modifier to indicate reduced services.

–RT and –LT Modifiers

HCPCS modifiers –RT (right side) and –LT (left side) don't affect payment They may be used with CPT® radiology codes 70010-79999 to identify duplicate procedures performed on opposite sides of the body.

Portable X-rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving
  - Extremities,
  - Pelvis,
  - Vertebral column or
  - Skull
- Chest or abdominal films that don't involve the use of contrast media
- Diagnostic mammograms

HCPCS codes for transportation of portable X-ray equipment R0070 (one patient) or R0075 (multiple patients) may be paid in addition to the appropriate radiology code(s). R0075 will pay based on the number of patients served and the modifier billed. Payment is outlined in the following table.

HCPCS Code	Modifier	Patients Served	Description	Fee
R0070		1	Transport portable X-ray	$164.84
R0075	–UN	2	Transport portable X-ray	$ 82.43
R0075	–UP	3	Transport portable X-ray	$ 54.95
R0075	–UQ	4	Transport portable X-ray	$ 41.21
R0075	–UR	5	Transport portable X-ray	$ 32.97
R0075	–US	6 or more	Transport portable X-ray	$ 27.48

Custody

X-rays must be retained for 10 years. See WACs 296-20-121 and 296-23-140(1).

RADIOLOGY CONSULTATION SERVICES

Attending health care providers who request second opinion consulting services are responsible for determining the necessity for the second opinion and must briefly document that justification in their chart notes. Examples include:

- Confirm or deny hypermobility at C5/C6
- Does this T12 compression fracture look old or new?
- Evaluate stability of L5 spondylolisthesis
- What is soft tissue opacity overlying sacrum? Will it affect case management for this injury?
- Is opacity in lung field anything to be concerned about?
- Does this disc protrusion shown on MRI look new or preexisting?

CPT® code 76140 **isn't covered**. For radiology codes where a consultation service is performed, providers must bill the specific X-ray code with the modifier –26. The insurer won't pay separately for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the X-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed. Payment for a radiological consultation will be made at the established professional component (modifier –26) rate for each specific radiology service. A written report of the consultation is required.

RADIOLOGY REPORTING REQUIREMENTS

Documentation for the professional interpretation of radiology procedures is required for all professional component billing whether billed with modifier -26 or as part of the global service. Documentation refers to charting of justification, findings, diagnoses, and test result integration.

Any provider who produces and interprets his/her own imaging studies, and any radiologist who overreads imaging studies must produce a report of radiology findings to bill for the professional component.

The radiology report of findings must be in written form and must include all of the following:

- Patient's name, age, sex, and date of procedure
- The anatomic location of the procedure and type of procedure (lumbar spine plain films, abdomen CT, cervical spine MRI, etc)
- Specific views (eg, AP, lateral, oblique, weight bearing, axial, sagittal, coronal, with or without contrast, etc, as applicable)
- Brief sentence summarizing history and/or reason for the study. Examples:
  - "Lower back pain; evaluate for degenerative changes and rule out leg length inequality."
  - "Neck pain radiating to upper extremity; rule out disc protrusion."
- Description of, or listing of, imaging findings:
  - Advanced imaging reports should follow generally accepted standards to include relevant findings related to the particular type of study.
  - Radiology reports on plain films of skeletal structures should include evaluation of osseous density and contours, important postural/mechanical considerations, assessment of any joint space abnormalities, and assessment of any important abnormal soft tissue findings.
  - Radiology reports on chest plain films should include assessment of lung fields, bronchovascular markings, apices, tracheal air shadow, mediastinal and hilar contours, cardiovascular contours, costophrenic recesses, any abnormalities below the diaphragm, and assessment of any important osseous abnormalities shown incidentally (ribs, clavicles, scapulae, proximal humeri, spine).

  NOTE: Chart notes such as "x-rays are negative" or "x-rays are normal" don't fulfill the reporting requirements described in this section and the insurer won't pay for the professional component in these circumstances.

- Impressions

  Imaging impressions summarize and provide significance for the imaging findings described in the body of the report. Examples include:

  - For a skeletal plain film report that described normal osseous density and contours and no joint abnormalities, the impression could be "No evidence of fracture, dislocation, or gross osseous pathology."
  - For a skeletal plain film report that described reduced bone density and thinned cortices, the impression could be "Osteoporosis, compatible with the patient's age."
  - For a chest report that described vertically elongated and radiolucent lung fields, low diaphragm, and long vertical heart, the impression could be "Emphysema."

Attending providers who produce or order diagnostic imaging studies are responsible for acknowledging and integrating the imaging findings into their case management. Providers must include brief documentation in their chart notes. Examples include:

- "Imaging rules out fracture, so rehab can proceed."
- "Flexion/extension plain films indicate hypermobility at C4/C5, and spinal manipulation will avoid that region."
- "MRI identifies disc protrusion at L4/L5, and a conservative course of inversion therapy will begin.

CONTRAST MATERIAL

Separate payment will be made for contrast material for imaging studies. Providers may use either high osmolar contrast material (HOCM) or low osmolar contrast material (LOCM). The use of either type of contrast material must be based on medical necessity.

The brand name of the contrast material and the dosage must be documented in the patient's chart. Use the following codes to bill for contrast material:

- LOCM: Q9951, Q9965 – Q9967
- HOCM: Q9958 - Q9964

HCPCS codes for LOCM are paid at a flat rate based on the AWP per ml. Bill 1 unit per ml. Code A9525 **isn't** valid for contrast material.

NUCLEAR MEDICINE

The standard multiple surgery policy applies to the following radiology codes for nuclear medicine services.

CPT® Code
78306
78320
78802
78803
78806
78807

The multiple procedures reduction will be applied when these codes are billed:

- With other codes that are subject to the standard multiple surgery policy, and
- For the same patient,
  - On the same day,
  - By the same physician or
  - By more than 1 physician of the same specialty in the same group practice.

Refer to the Surgery Services section for more information about the standard multiple surgery payment policies.

PHYSICAL MEDICINE

GENERAL INFORMATION

Physical and occupational therapy services must be ordered by the worker's:

- Attending doctor
- Nurse practitioner or
- By the physician assistant for the attending doctor.

Who May Bill For Physical Medicine Services

Board Certified Physical Medicine and Rehabilitation (Physiatry) Physicians

Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation may provide physical medicine services.

- They use CPT® codes 97001 through 97799 and 95831 through 95852 to bill for their services.
- CPT® code 64550 may also be used but is payable only once per claim (see WAC 296-21-290).

Licensed Physical Therapists

Physical therapy services must be provided by a licensed physical therapist or a physical therapist assistant serving under the supervision of a licensed physical therapist (see WAC 296-23-220).

Licensed Occupational Therapists

Occupational therapy services must be provided by a licensed occupational therapist or occupational therapy assistant serving under the direction of a licensed occupational therapist (see WAC 296-23-230).

Nonboard Certified/Qualified Physical Medicine Providers

Special payment policies apply for attending doctors who aren't board qualified or certified in physical medicine and rehabilitation:

- They **won't be paid** for CPT® codes 97001-97799.
- They may perform physical medicine modalities and procedures described in CPT® codes 97001-97750 if their scopes of practice and training permit it, but must bill local code 1044M for these services.
- Local code 1044M is limited to 6 units per claim, except when the attending provider practices in a remote location where no licensed physical therapist is available.
- After 6 units, the patient must be referred to a licensed, physical or occupational therapist or physiatrist for such treatment except when the attending provider practices in a remote location. Refer to WAC 296-21-290 for more information.

1044M Physical medicine modality (ies) and/or procedure(s) by attending provider who isn't board qualified or certified in physical medicine and rehabilitation. Limited to 6 units except when provider practices in a remote area. ..... $ 43.06

Who Won't Be Paid For Physical Medicine Services

- Physical or occupational therapist students
- Physical or occupational therapist assistant students
- Physical or occupational therapist aides
- Athletic trainers

PHYSICAL AND OCCUPATIONAL THERAPY

Billing Codes

Physical and occupational therapists must use the appropriate CPT® and HCPCS codes 64550, 95831-95852, 95992, 97001-97799 and G0283, with the exceptions noted later in the Noncovered and Bundled Codes section. They must bill the appropriate **covered** HCPCS codes for miscellaneous materials and supplies. For information on surgical dressings dispensed for home use, refer to the Supplies, Materials and Bundled Services section, page **135**. If more than 1 patient is treated at the same time use CPT® code 97150. Refer to the Physical Medicine CPT® Codes Billing Guidance section, page **70** for additional information.

Noncovered and Bundled Codes

The following physical medicine codes aren't covered:

CPT® Code
97005
97006
97033

The following are examples of bundled items or services:

- Application of hot or cold packs.
- Ice packs, ice caps and collars.
- Electrodes and gel.
- Activity supplies used in work hardening, such as leather and wood.
- Exercise balls.
- Theratаping.
- Wound dressing materials used during an office visit and/or physical therapy treatment.

Refer to the appendices for complete lists of noncovered and bundled codes.

Untimed Services

Supervised modalities and therapeutic procedures that don't list a specific time increment in their description are limited to 1 unit per day:

CPT® Code	CPT® Code
97001	97018
97002	97022
97003	97024
97004	97026
97012	97028
97014	97150
97016	

Daily Maximum for Services

The daily maximum allowable fee for physical and occupational therapy services (see WAC 296-23-220and WAC 296-23-230 ..... $ 118.07

The daily maximum applies to CPT® codes 64550, 95831-95852 and 97001-97799 and HCPCS code G0283 when performed for the same claim for the same date of service. If physical, occupational, and massage therapy services are provided on the same day, the daily maximum applies once for each provider type.

If the worker is treated for 2 separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

If part of the visit is for a condition unrelated to an accepted claim and part is for the accepted condition, therapists must apportion their usual and customary charges equally between the insurer and the other payer based on the level of service provided during the visit. In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer doesn't have the right to see information about an unrelated condition.

The daily maximum allowable fee doesn't apply to:

- Performance based physical capacities examinations (PCEs),
- Work hardening services,
- Work evaluations or
- Job modification/prejob accommodation consultation services.

PHYSICAL AND OCCUPATIONAL THERAPY EVALUATIONS

Use CPT® codes 97001 through 97004 to bill for physical and occupational therapy evaluations and reevaluations. Use CPT® codes 97001 and 97003 to report the evaluation by the physician or therapist to establish a plan of care. Use CPT® codes 97002 and 97004 to report the evaluation of a patient who has been under a plan of care established by the physician or therapist in order to revise the plan of care. CPT® codes 97002 and 97004 have no limit on how frequently they can be billed.

PHYSICAL CAPACITIES EVALUATION

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists. The evaluation must be provided as a 1-on-1 service.

1045M Performance-based physical capacities evaluation with report and summary of capacities ..... $ 705.78
(Limit of 1 per 30 days)

POWERED TRACTION THERAPY

Powered traction devices **are covered** as a physical medicine modality.

The insurer **won't pay** any additional cost when powered devices are used. Published literature has not substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices. For more information go to

http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Pwdtractiondevices.asp

WOUND CARE

Debridement

Therapists must bill CPT® 97597, 97598 or 97602 when performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool).

Wound dressings and supplies used in the office are bundled and aren't separately payable.

Wound dressings and supplies sent home with the patient for self-care can be billed with HCPCS codes appended with local modifier –1S. See the Supplies, Materials and Bundled Services section, page **135** for more information.

Electrical Stimulation for Chronic Wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing. Electrical stimulation is **covered** for the following chronic wound indications:

- Stage III and IV pressure ulcers
- Arterial ulcers
- Diabetic ulcers
- Venous stasis ulcers

Prior authorization is required if electrical stimulation for chronic wounds is requested for use on an outpatient basis using the following criteria:

- Electrical stimulation will be authorized if the wound hasn't improved following 30 days of standard wound therapy.
- In addition to electrical stimulation, standard wound care must continue.
- In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Use HCPCS code G0281 to bill for electrical stimulation for chronic wounds. For more information go to

http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ElecStimofChronicWounds.asp

MASSAGE THERAPY

Massage is a **covered** physical medicine service when performed by a licensed massage therapist (WAC 296-23-250) or other covered provider whose scope of practice includes massage techniques.

Massage therapists must bill CPT® code 97124 for all forms of massage therapy, regardless of the technique used. The insurer **won't pay** massage therapists for additional codes.

Massage therapists must bill their usual and customary fee and designate the duration of the massage therapy treatment.

Massage therapy is paid at 75% of the maximum daily rate for physical and occupational therapy services and the daily maximum allowable amount is ..... $ 88.55

The following are bundled into the massage therapy service and aren't separately payable:

- Application of hot or cold packs,
- Anti-friction devices and
- Lubricants (For example, oils, lotions, emollients).

Refer to WAC 296-23-250 for additional information.

Document the amount of time spent performing the treatment. Your documentation must support the units of service billed.

PHYSICAL MEDICINE CPT® CODES BILLING GUIDANCE

Timed Codes

Some physical medicine services (e.g. ultrasound and therapeutic exercises) are billed based on the number of minutes spent performing the service. These services are referred to as 'timed services' and are billed using 'timed codes'.

Timed codes can be identified in CPT® by the code description. The definition will include words such as 'each 15 minutes'.

Providers **must document** in the daily medical record (chart note and flow sheet, if used):

- the amount of time spent for each time based service performed
- the specific interventions or techniques performed, including:
- frequency and intensity (if appropriate), and
- intended purpose of each intervention or technique.

Simply documenting the procedure code and the amount of time the service is performed is insufficient and may result in denial of the bill or recoupment of payment. All documentation must be submitted to support your billing (e.g. flow sheets, chart notes, and reports.)

Documenting a range of time (e.g. 8-22 minutes) for a timed service isn't acceptable. Providers must document the actual amount of minutes spent performing the service.

The number of units you can bill is determined by the time spent performing each 'timed service', and is constrained by the total number of minutes spent performing these services on a given day. Add together the minutes spent performing each individual time based service to obtain the total minutes spent performing time based services, and use the table below to obtain the number of units that can be billed for these services.

Units Reported	Number Minutes
1 unit	≥ 8 minutes to < 23 minutes
2 units	≥ 23 minutes to < 38 minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥113 minutes to < 128 minutes

NOTE: The above schedule of times doesn't imply that any minute until the 8th should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

For example, if you perform 10 minutes of CPT® 97110 (therapeutic exercises) and 12 minutes of CPT® 97140 (manual therapy), you have performed 22 minutes of 'timed code' services. This equates to 1 unit of service that can be billed. Since the most time was spent performing manual therapy, bill 1 unit of 97140.

Examples

The following charts are examples of how the required elements of interventions can be documented. These examples aren't reflective of a complete medical record for the patient's visit. The other elements of reporting (SOAP) must also be documented.

Example 1

Time	Procedural Intervention	Specific Intervention	Purpose
20'	Therapeutic Exercise	Left leg-Straight Leg Raises X 4 directions; 3 lbs. each direction. 10 reps x 2 sets	Strength and endurance training for lifting
15'	Neuromuscular Reeducation	One leg stance 45 seconds left, 110 seconds on right using balance board x 2 sets each	Normalize balance for reaching overhead
10'	Cold Pack	Applied to left knee	Decrease edema

Total timed intervention: 35 minutes

Total treatment time: 45 minutes

The total treatment time spent performing timed services is 35 minutes. A maximum of 2 units of timed services can be billed. **Correct billing of these services is:**

- 97110 (therapeutic exercise) X 1 unit; and
- 97112 (neuromuscular reeducation) X 1 unit

Example 2

Time	Procedural Intervention	Specific Intervention	Purpose
8'	Attended E-Stim and Ultrasound performed simultaneously	5mA right forearm 1.5 W/cm^2; 100% right forearm	Increase joint mobility
8'	Whirlpool	Heat bath to right forearm and hand	Facilitate movement; reduce inflammation
10'	Therapeutic Exercise	Active assisted ROM to right wrist; flexion/extension; 15 reps x 2 sets	Increase motion and strength for gripping

Total timed intervention: 18 minutes

Total treatment time: 26 minutes

The total treatment time spent performing timed services is 18 minutes. A maximum of 1 unit of timed service can be billed. **Correct billing of these services is:**

- 97110 (therapeutic exercise) X 1 unit; and
- 97022 (whirlpool) X 1 unit

Prohibited Pairs

A therapist can't bill any of the following pairs of CPT® codes for outpatient therapy services provided simultaneously to 1 or more patients **for the same time period**.

- Any 2 CPT® codes for "therapeutic procedures" requiring direct, 1-on-1 patient contact.
- Any 2 CPT® codes for modalities requiring "constant attendance" and direct, 1-on-1 patient contact.
- Any 2 CPT® codes requiring either constant attendance or direct, 1-on-1 patient contact—as described above—. For example: any CPT® codes for a therapeutic procedure with any attended modality CPT® code.
- Any CPT® code for therapeutic procedures requiring direct, 1-on-1 patient contact with the group therapy CPT® code. For example: CPT® code 97150 with CPT® code 97112.
- Any CPT® code for modalities requiring constant attendance with the group therapy code. For example: (CPT® code 97150 with CPT® code 97035)
- Any untimed evaluation or reevaluation code with any other timed or untimed CPT® codes, including constant attendance modalities, therapeutic procedures and group therapy.

DETERMINING WHAT TIME COUNTS TOWARDS TIMED CODES

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services aren't to be counted in determining the treatment service time. In other words, the time counted as "intraservice care" begins when the therapist or physician (or a physical therapy or occupational therapy assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (For example, on the treatment table or mat or in the gym) and prepared to begin treatment. The time counted is the time the patient is treated. The time the patient spends not being treated because of the need for toileting or resting shouldn't be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin isn't considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services won't be exceeded.

More information about L&I's Physical, Occupational and Massage Therapy policies is also available on L&I's web site at
http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/Therapy/default.asp

WORK CONDITIONING AND WORK HARDENING

Work Conditioning

Work Conditioning is an intensive, work-related, goal-oriented conditioning program designed specifically to restore function for work. These programs are reimbursed as outpatient occupational and physical therapy under the daily fee cap. See WAC 296-23-220 and WAC 296-23-230.

Guidelines:

- Frequency: at least 3 times per week and no more than 5 times per week
- Duration: No more than 8 weeks for 1 set. 1 set equals up to 20 visits.
- An additional 10 visits may be approved upon review of progress
- Plan of Care: Goals are related to:
  - increasing physical capacities;
  - return to work function; and
  - establishing a home program allowing the individual to progress and/or maintain function after discharge.
- Documentation: Includes return to work capacities which may include lifting, carrying, pushing, pulling, sitting, standing, and walking tolerances
- Treatment: May be provided by a single therapy discipline (PT or OT) or combination of both (PT and OT).
  - Physical and occupational therapy visits accumulate separately and both are allowed on the same date of service.
  - Billing reflects active treatment. Examples include CPT 97110, 97112, 97530, 97535, and 97537.

Work Hardening

Work hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular and psychosocial functioning of the worker. Work hardening programs require prior approval by the worker's attending physician and **prior authorization** by the claim manager.

Only L&I approved work hardening providers will be paid for work hardening services.

More information about L&I's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program and other work hardening program standards is available on L&I's web site at http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/WorkHard/default.asp

This information is also available by calling the work hardening program reviewer at (360) 902-4480.

The work hardening evaluation is billed using local code 1001M. Treatment is billed using CPT® codes 97545 and 97546. These codes are subject to the following limits:

Work hardening programs are authorized for up to 4 weeks.

Code	Description	Unit limit (four week program)	Unit price
1001M	Work hardening evaluation	6 units (1 unit = 1 hour)	$ 117.02
97545	Initial 2 hours per day	20 units per program; max.1unit per day per worker (1 unit = 2 hours)	$ 133.37
97546	Each additional hour	70 units per program; add-on, won't be paid as a stand-alone procedure per worker per day. (1 unit = 1 hour)	$ 62.53

Program extensions

Program extensions must be authorized in advance by the claim manager and are based on documentation of progress and the worker's ability to benefit from the program extension up to 2 additional weeks. Additional units available for extended programs

Code	Description	6 week program limit
1001M	Work hardening evaluation	no additional units
97545	Initial 2 hours per day	10 units (20 hours)
97546	Each additional hour	50 units (50 hours)

Providers may only bill for the time that services are provided in the presence of the client. The payment value of procedure codes 97545 and 97546 takes into consideration that some work occurs outside of the time the client is present (team conference, plan development, etc.).

Time spent in treatment conferences **isn't covered** as a separate procedure regardless of the presence of the patient at the conference. Job coaching and education are provided as part of the work hardening program. These services must be billed using procedure codes 97545 and 97546.

Billing for additional services

The provision of additional services during a work hardening program is atypical and must be authorized in advance by the claim manager. Documentation must support the billing of additional services.

Billing for less than 2 hours of service in 1 day (97545)

Services provided for less than 2 hours on any day don't meet the work hardening program standards. Therefore, the services must be billed outside of the work hardening program codes. For example, the worker arrives for work hardening but is unable to fully participate that day. Services should be billed using CPT® codes that appropriately reflect the services provided. This should be considered as an absence in determining worker compliance with the program. The standard for participation continues to be a minimum of 4 hours per day, increasing each week to 7-8 hours per day by week 4.

Billing less than 1 hour of 97546

After the first 2 hours of service on any day, if less than 38 minutes of service are provided the -52 modifier must be billed. For that increment of time, procedure code 97546 must be billed as a separate line item with a -52 modifier and the charged amount prorated to reflect the reduced level of service. For example: Worker completes 4 hours and 20 minutes of treatment. Billing for that date of service would include 3 lines:

Code	Modifier	Charged Amt	Units
97545		Usual and customary	1
97546		Usual and customary	2
97546	-52	33% of usual and customary (completed 20 of 60 minutes)	1

Billing for services in multidisciplinary programs

Each provider must bill for the services that they are responsible for each day. Both occupational and physical therapists may bill for the same date of service.

Only 1 unit of 97545 (first 2 hours) will be paid per day per worker and the total number of hours billed shouldn't exceed the number of hours of direct services provided.

Example: The occupational therapist (OT) is responsible for the work simulation portion of the worker's program, which lasted 4 hours. On the same day, the worker performed 2 hours of conditioning/aerobic activity that the physical therapist (PT) is responsible for. The 6 hours of services could be billed in 1 of 2 ways.

Option 1		
PT	1 unit 97545	2 hours
OT	4 units 97546	4 hours
	Total hours billed	6 hours

Option 2		
OT	1 unit 97545 + 2 units 97546	2 hours 2 additional hours
PT	2 units 97546	2 hours
	Total hours billed	6 hours

Billing for evaluation and treatment on the same day – multiple disciplines

If both the OT and the PT need to bill for 1 hour of evaluation and 1 hour of treatment on the same date of service, the services must be billed as follows:

Provider	Service	Bill As:
OT	1 hour evaluation	1 unit 1001M
PT	1 hour evaluation	1 unit 1001M
OT (or PT)	1 hour treatment	1 unit 97545 with modifier -52 (billed amount proportionate to 1 hour)
PT (or OT)	1 hour treatment	1 unit 97546

OSTEOPATHIC MANIPULATIVE TREATMENT

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT). CPT® code 97140 **isn't covered** for osteopathic physicians.

For OMT services body regions are defined as:

- Head
- Cervical
- Thoracic
- Lumbar
- Sacral
- Pelvic
- Rib cage
- Abdomen and viscera regions
- Lower and upper extremities

These codes ascend in value to accommodate the additional body regions involved. Therefore, only 1 code is payable per treatment. For example, if 3 body regions were manipulated, 1 unit of the correct CPT® code would be payable.

OMT includes pre- and post-service work (For example, cursory history and palpatory examination). E/M office visit service may be billed in conjunction with OMT **only when all of the following conditions are met:**

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT, and
- There is documentation in the patient's record supporting the level of E/M billed, and
- The E/M service is billed using the –25 modifier.

The insurer **won't pay** for E/M codes billed on the same day as OMT without the –25 modifier.

The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis isn't required for payment of E/M in addition to OMT services on the same day.

The insurer may reduce payments or process recoupments when E/M services aren't documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

ELECTRICAL STIMULATORS

Electrical Stimulators Used in the Office Setting

Providers may bill professional services for application of stimulators with the CPT® physical medicine codes when it is within the provider's scope of practice. Attending providers who aren't board qualified or certified in physical medicine and rehabilitation must bill local code 1044M.

Devices and Supplies for Home Use or Surgical Implantation

See the Transcutaneous Electrical Nerve Stimulators (TENS) section for policies pertaining to TENS units and supplies. Coverage policies for other electrical stimulators and supplies are described as follows.

Electrical Stimulator Devices for Home Use or Surgical Implantation

HCPCS Code	Brief Description	Coverage Status
E0744	Neuromuscular stim for scoli	Not covered
E0745	Neuromuscular stim for shock	Covered for muscle denervation only. Prior authorization is required.
E0747	Elec Osteo stim not spine	Prior authorization is required.
E0748	Elec Osteogen stim spinal	Prior authorization is required
E0749	Elec Osteogen stim, implanted	Authorization subject to utilization review.
L8680	Implantable neurostimulator electrode	Not covered
E0755	Electronic salivary reflex s	Not covered
E0760	Osteogen ultrasound, stimltor	Covered for appendicular skeleton only (not the spine). Prior authorization is required.
E0761	Nontherm electromgntc device	Covered
E0762	Trans elec jt stim dev sys	Not covered
E0764	Functional neuromuscular stimulator	Prior authorization is required
E0765	Nerve stimulator for tx n&v	Not covered
E0769	Electric wound treatment dev	Not covered

Electrical Stimulator Supplies for Home Use

HCPCS Code	Brief Description	Coverage Status
A4365	Adhesive remover wipes	Payable for home use only Bundled for office use
A4455	Adhesive remover per ounce	
A4556	Electrodes, pair	
A4557	Lead wires, pair	
A4558	Conductive paste or gel	
A5120	Skin barrier wipes box per 50	
A6250	Skin seal protect moisturizer	
E0731	Conductive garment for TENS	Not covered
E0740	Incontinence treatment system	Not covered

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

Transcutaneous electrical nerve stimulation (TENS), interferential current therapy (IFC) and percutaneous neuromodulation therapy (PNT) devices for use outside of medically supervised facility settings **aren't covered** for State Fund, Self-Insured and Crime Victims claims. This includes home use, purchase or rental of durable medical equipment (DME) and supplies. Use of these therapies will continue to be covered during hospitalization and in supervised facility settings.

On October 30, 2009, the State Health Technology Clinical Committee (HTCC) met in an open public meeting to review the evidence for Electrical Nerve Stimulation (ENS), including TENS, IFC and PNT, as treatments for acute and chronic pain. Based on a review of the best available evidence of safety, efficacy and cost-effectiveness, the committee's determination is that ENS is noncovered for use outside of medically supervised facilities. Purchase or rental of TENS, IFC, and PNT equipment and supplies isn't covered. The determination was made final by the HTCC on November 20, 2009. Complete information on this HTCC determination is available at: http://www.hta.hca.wa.gov.

CHIROPRACTIC SERVICES

Chiropractic physicians must use the codes listed in this section to bill for services. In addition, they must use the appropriate CPT® codes for radiology, office visits and case management services and HCPCS codes for miscellaneous materials and supplies.

CHIROPRACTIC EVALUATION AND MANAGEMENT

Chiropractic physicians may bill the first 4 levels of new and established patient office visit codes. L&I uses the CPT® definitions for new and established patients. If a provider has treated a patient for any reason within the last 3 years, the person is considered an established patient. Refer to a CPT® book for complete code descriptions, definitions and guidelines.

The following payment policies apply when chiropractic physicians use E/M office visit codes:

- A new patient E/M office visit code is **payable only once** for the initial visit.
- An established patient E/M office visit code isn't payable on the same day as a new patient E/M office visit code.
- Office visits in excess of 20 visits or that occur more than 60 days after the first date you treat the worker require **prior authorization**.
- Modifier –22 isn't payable with E/M codes for chiropractic services.
- Established patient E/M codes are **not payable** in addition to L&I chiropractic care visit codes for follow-up visits.
- Refer to the Chiropractic Care Visits section for policies about the use of E/M office visit codes with chiropractic care visit codes.

Case Management

Refer to Case Management Services, page **40** in the Evaluation and Management section for information on billing for case management services telephone calls, team conferences, and secure e-mail). These codes may be paid in addition to other services performed on the same day.

Consultations

Approved chiropractic consultants may bill the first 4 levels of CPT® office consultation codes. L&I periodically publishes:

- A policy on consultation referrals and
- A list of approved chiropractic consultants

The most recent policy, list of approved consultants and how to become a chiropractic consultant is available on the L&I web at

http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/BySpecialty/ChiroSvcs.asp

Physical Medicine Treatment

Local code 1044M (physical medicine modality (ies) and/or procedure(s) by attending provider not board qualified/certified in Physical Medicine & Rehabilitation (PM&R)) may be billed up to 6 units per claim (not per attending provider), except when the provider practices in a remote area. Refer to the previous section Non-Board Certified/Qualified Physical Medicine providers, page **66** for more information. Documentation of the visit must support billing for this procedure code.

CPT® physical medicine codes 97001-97799 are not payable to chiropractic physicians.

Powered Traction Devices

Powered traction devices are **covered** as a physical medicine modality under existing physical medicine payment policy. The insurer will not pay any additional cost when powered devices are used. Published literature has not substantially shown that powered devices are more effective than other forms of traction, other conservative treatments, or surgery. This policy applies to all FDA-approved powered traction devices. When powered traction is a proper and necessary treatment, the insurer may pay for powered traction therapy administered by a qualified provider. Nonboard certified/qualified physical medicine providers must use 1044M. Therapy is **limited to 6 units per claim** except when the provider practices in a remote area.

Only 1 unit of the appropriate billing code will be paid per visit, regardless of the length of time the treatment is applied. For additional information see "Powered Traction Therapy", page **68** in the Physical Medicine section of this document.

Complementary and Preparatory Services

Chiropractic physicians are not separately paid for patient education or complementary and preparatory services. L&I defines complementary and preparatory services as interventions used to prepare a body region for or facilitate a response to a chiropractic manipulation/ adjustment. The application of heat or cold is considered a complementary and preparatory service. Examples of patient education or counseling include discussion about:

- Lifestyle
- Diet
- Self-care and activities of daily living
- Home exercises

CHIROPRACTIC CARE VISITS

Chiropractic care visits are defined as office or other outpatient visits involving subjective and objective assessment of patient status, management and treatment. CPT® codes for chiropractic manipulative treatment (98940-98943) **aren't covered**. L&I collaborated with the Washington State Chiropractic Association and the University of Washington to develop the local codes that are covered for chiropractic services. The codes account for these components of treating workers:

- Professional management (clinical complexity), and
- Technical service (manipulation and adjustment)

Local codes for chiropractic care visits:

2050A Level 1: Chiropractic Care Visit (straightforward) ..... $ 41.20
2051A Level 2: Chiropractic Care Visit (low complexity) ..... $ 52.76
2052A Level 3: Chiropractic Care Visit (moderate complexity) ..... $ 64.29

Clinical complexity is similar to established patient evaluation and management services, but emphasizes factors typically addressed with treating workers. Factors that contribute to visit complexity include:

- The current occupational condition(s)
- Employment and workplace factors
- Nonoccupational conditions that may complicate care of the occupational condition
- Chiropractic intervention(s) provided (including the number of body regions manipulated)
- Care planning and patient management
- Response to care

NOTE: The number of body regions being adjusted is only one of the factors that may contribute to visit complexity. It isn't the only factor as it is in the CPT® chiropractic manipulation treatment (CMT) codes.

Payment Policies for Chiropractic Care Visits

- **Only 1** chiropractic care visit code is payable per day.
- Extremities are considered as one body region and are **not billed separately**.
- Office visits in excess of 20 visits or that are more than 60 days after the first treatment date require **prior authorization** per WAC 296-20-03001(1).
- Modifier –22 will be individually reviewed when billed with chiropractic care visit local codes (2050A-2052A). Submit a report detailing the nature of the unusual service and the reason it was required. Payment will vary based on the review findings. This modifier isn't **payable** when used for noncovered or bundled services (for example: application of hot or cold packs).

Use of Chiropractic Care Visit Codes with E/M Office Visit Codes

Chiropractic care visit codes (local codes 2050A-2052A) are payable in addition to E/M office visit CPT® codes (99201-99204, 99211-99214) **only when all of the following conditions are met:**

- The E/M service is for the initial visit on a new claim; and
- The E/M service is a significant, separately identifiable service (exceeds the usual pre- and post-service work included in the chiropractic care visit); and
- Modifier –-25 is added to the patient E/M code; and
- Supporting documentation describing the service(s) is in the patient's record.

Billing Tip

When a patient requires reevaluation for an existing claim:

- Either an established patient E/M code **or**
- A chiropractic care local code (2050A-2052A) is payable **and**
- Modifier –25 isn't applicable in this situation.

Selecting the Level of Chiropractic Care Visit Code

The following table outlines the treatment requirements, presenting problems and face-to-face patient time involved in the 3 levels of chiropractic care visits. Clinical decision making complexity is the primary component in selecting the level of the visit. L&I defines clinical decision making complexity according to the definitions for medical decision making complexity in the *Evaluation and Management Services Guidelines* section of the CPT® book.

If the **clinical decision-making** is…	and the typical **number of body regions*** manipulated is…	and the **typical face-to-face time** with patient or family is…	Then the **appropriate billing code** is:
Straightforward	Up to 2	Up to 10-15 minutes	**Level 1 (2050A)**
Low complexity	Up to 3 or 4	Up to 15-20 minutes	**Level 2 (2051A)**
Moderate complexity	Up to 5 or more	Up to 25-30 minutes	**Level 3 (2052A)**

* Body regions for chiropractic services are defined as:

- Cervical (includes atlanto-occipital joint)
- Thoracic (includes costovertebral and costotransverse joints)
- Lumbar
- Sacral
- Pelvic (includes sacro-iliac joint)
- Extraspinal: Any and all extraspinal manipulations are considered to be **one region**. Extraspinal manipulations include:
- Head (including temporomandibular joint, excluding atlanto-occipital)
- Lower extremities
- Upper extremities

- Rib cage (excluding costotransverse and costovertebral joints)

Chiropractic Care Visit Examples

The following examples of chiropractic care visits are for illustrative purposes only. They are not intended to be clinically prescriptive.

EXAMPLES	
Level 1 Chiropractic Care Visit **(Straightforward)**	**Patient**: 26-year-old male. **Injury**: Lifting a box at work. **Presenting Problems**: Mild, lower back pain for several days after injury. **Treatment**: Manipulation/ adjustment of the lumbar region, anterior thoracic mobilization and lower cervical adjustment.
Level 2 Chiropractic Care Visit **(Low complexity)**	**Patient**: 55-year-old male, follow-up visit. **Injury**: Slipped and fell near the bottom of a stairwell while carrying a printer at work. **Presenting Problems**: Ongoing complaints of neck pain and lower back pain. Today, worker reports new sensation of periodic tingling in right foot. He was off work for 2 days. **Treatment**: Discussion of need to minimize lifting and getting assistance with heavier objects. Worker receives 5 minutes of myofascial release prior to adjusting the cervical, thoracic and lumbar regions.
Level 3 Chiropractic Care Visit **(Moderate complexity)**	**Patient**: 38-year-old female. **Injury**: Moving heavy archive boxes at work over a 3-day period. **Presenting Problems**: Headache, right anterior rib pain, low back pain with pain at the sacrococcygeal junction, as well as pain in the sacroiliac regions and right-sided foot drop. She tried to return to light duty last week, but was unable to sit for very long and went home. She is obese and mentioned in her history that she might have borderline diabetes. Worker reports she tried to do the stretching prescribed during her last visit but they hurt so she did not do them. **Treatment**: Reviewed MRI report with the worker. She receives 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/adjustment to the cervical and atlanto-occipital, thoracic, anterior rib area, lumbar, sacroiliac and sacrococcygeal regions.

CHIROPRACTIC INDEPENDENT MEDICAL EXAMS

Chiropractic physicians must be approved examiners by the department prior to performing independent medical exams (IMEs) or impairment ratings. Before applying for approval, chiropractic physicians must meet the following requirements:

- Complete two years as an approved chiropractic consultant and
- Complete an impairment rating course approved by the department;

The above mentioned course is offered as part of the Chiropractic Consultant Program. For more information refer to http://www.lni.wa.gov/ClaimsIns/Providers/Becoming/Chiropractic/default.asp or the *Medical Examiners' Handbook* (publication F252-001-000).

http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1668.

Attending chiropractic physicians who are approved IME examiners may:

- Perform impairment ratings on their own patients or
- Refer to an approved examiner for a consultant impairment rating. See page **97**, later in this section.

CHIROPRACTIC RADIOLOGY SERVICES

Chiropractic physicians must bill diagnostic X-ray services using CPT® radiology codes and the policies described in the Radiology Services section, page **62**.

When medically necessary, X-rays immediately prior to and following the initial chiropractic adjustment **are allowed** without prior authorization. X-rays subsequent to the initial study require **prior authorization**.

Only chiropractic physicians that are on L&I's list of approved radiological consultants may bill for X-ray consultation services. To qualify, a chiropractic physician must be a Diplomat of the American Chiropractic Board of Radiology and must be approved by L&I.

SUPPLIES

See the Supplies, Materials and Bundled Services section, page **135** to find information about billing for supplies.

PSYCHIATRIC SERVICES

The psychiatric services policies in this section apply to workers covered by the State Fund and self-insured employers (see WAC 296-21-270). Refer to the Medical Treatment Guideline for Psychiatric and Psychological Evaluation at http://www.Lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/PsychEval.pdf for information on:

- Treatment guidelines
- Psychiatric conditions
- Reporting requirements
- Diagnosis of a psychiatric condition
- Identifying barriers that hinder recovery from an industrial injury
- Formulation of a psychiatric treatment plan
- Assessment of psychiatric treatment and recommendations

For information on psychiatric policies applicable to the Crime Victims' Compensation Program, refer to http://www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/Default.asp and Chapter 296-31 WAC.

PROVIDERS OF PSYCHIATRIC SERVICES

Authorized psychiatric services **must** be performed by a psychiatrist (MD or DO), a psychiatric Advanced Registered Nurse Practitioner (ARNP), or a licensed clinical PhD or PsyD psychologist (see WAC 296-21-270).

Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service.

Psychiatric ARNPs are paid at 90% of the values listed in the fee schedule.

Psychiatric evaluation and treatment services provided by social workers, and other master's level counselors, **are not covered** even when delivered under the direct supervision of a clinical psychologist or a psychiatrist.

Staff supervised by a psychiatrist, psychiatric ARNPs, or licensed clinical psychologist may administer psychological testing; however, the psychiatrist, or licensed clinical psychologist must interpret the testing and prepare the reports.

PSYCHIATRISTS OR PSYCHIATRIC ARNPS AS ATTENDING PROVIDERS

A psychiatrist or psychiatric ARNP can only be a worker's attending provider when the insurer has accepted a psychiatric condition and it is the **only** condition being treated. A psychiatrist or psychiatric ARNP may certify a worker's time loss from work if a psychiatric condition has been allowed and the psychiatric condition is the only condition still being treated. A psychiatrist may also rate psychiatric permanent partial disability. A psychiatric ARNP may not rate permanent partial disability.

Psychologists cannot be the attending provider and may not certify time loss from work or rate permanent partial disability per WAC 296-20-01002 (Doctor).

NONCOVERED AND BUNDLED PSYCHIATRIC SERVICES

The following services **aren't covered:**

CPT® Code	CPT® Code
90802	90845
90810-90815	90846
90823-90829	90849
90857	

The following services are bundled and **aren't payable separately:**

CPT® Code
90885
90887
90889

PSYCHIATRIC CONSULTATIONS AND EVALUATIONS

Prior authorization is required for all psychiatric care referrals (see WAC 296-21-270). This requirement includes referrals for psychiatric consultations and evaluations.

When an authorized referral is made to a psychiatrist or psychiatric ARNP, they may bill either the E/M consultation codes or the psychiatric diagnostic interview exam code.

When an authorized referral is made to a clinical psychologist for an evaluation, they may bill only CPT® code 90801.CPT® code 90801 is limited to 1 occurrence every 6 months, per patient, per provider.

Refer to WAC 296-20-045 and WAC 296-20-051 for more information on consultation requirements.

Telephone psychology services are **not covered**. Refer to the Teleconsultation and Other Telehealth Services section, page **44** for further details.

CASE MANAGEMENT SERVICES

Psychiatrists, psychiatric ARNPs, and clinical psychologists may only bill for case management services (telephone calls, team conferences and secure e-mail) when providing consultation or evaluation.

For payment criteria and documentation requirements, see Case Management Services in the Evaluation and Management section, page **40**.

INDIVIDUAL INSIGHT ORIENTED PSYCHOTHERAPY

Individual insight oriented psychotherapy services are divided into:

- Services with an E/M component, and
- Services without an E/M component.

Coverage of these services is different for psychiatrists and psychiatric ARNPs, and clinical psychologists.

Psychiatrists and psychiatric ARNPs may bill individual insight oriented psychotherapy codes (CPT® 90804-90809, 90816-90819, 90821-90822) either with or without an E/M component.

Psychotherapy with an E/M component may be billed when other services are conducted along with psychotherapy such as:

- Medical diagnostic evaluation,
- Drug management,
- Writing physician orders,
- Interpreting laboratory or other medical tests.

Clinical psychologists may bill only the individual insight oriented psychotherapy codes without an E/M component. They may not bill psychotherapy with an E/M component because medical diagnostic evaluation, drug management, writing physician orders and/or interpreting laboratory or other medical tests are outside the scope of a clinical psychologist's license.

Further explanation of this policy and CMS's response to public comments are published in *Federal Register* Volume 62 Number 211, issued on October 31, 1997. This is available on line at http://www.gpoaccess.gov/fr/index.html.

Billing Tip

To report individual psychotherapy, use the time frames in the CPT® code descriptions for each unit of service. When billing these codes, don't bill more than 1 unit per day. When the time frame is exceeded for a specific code, bill the code with the next highest time frame.

USE OF CPT® EVALUATION AND MANAGEMENT CODES FOR PSYCHIATRIC OFFICE VISITS

Psychologists may not bill the E/M codes for office visits.

Psychiatrists and psychiatric ARNPs may **only** bill the E/M codes for office visits on the same day psychotherapy is provided **if** it's medically necessary to provide an E/M service for a condition other than that for which psychotherapy has been authorized. The provider must submit documentation of the event and request a review before payment can be made.

PHARMACOLOGICAL EVALUATION AND MANAGEMENT

Pharmacological evaluation is payable only to psychiatrists and psychiatric ARNPs. If a pharmacological evaluation and psychotherapy are conducted on the same day, then the psychiatrist or psychiatric ARNP bills the appropriate psychotherapy code with an E/M component.

In this case, the psychiatrist or psychiatric ARNP must not bill the individual psychotherapy code and a separate E/M code (CPT® codes 99201-99215). Payment **isn't allowed** for psychotherapy and pharmacological management services performed on the same day, by the same provider, for the same patient.

HCPCS code M0064 isn't **payable with**:

- CPT® code 90862
- CPT® E/M office visit or
- Consultation codes (CPT® codes 99201-99215, 99241-99255).

HCPCS code M0064 is described "Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in treatment of mental psychoneurotic and personality disorders."

It is paid only if these described conditions are accepted or treatment is temporarily allowed by the insurer.

NEUROPSYCHOLOGICAL TESTING

The following codes may be used when performing neuropsychological evaluation. Reviewing records and/or writing/submitting a report is included in these codes and may not be billed separately.

CPT® Code	May be billed:
90801	Once every 6 months per patient per provider.
96101 and 96102	Up to a combined 4 hour maximum. In addition to CPT® codes 96118 and 96119.
96118 and 96119	Per hour up to a combined 12 hour maximum.

The psychologist is responsible to release test data to the insurer. Test data includes the injured worker's test results, raw test data, records, written/computer-generated reports, global scores or individuals scale scores, and test materials such as test protocols, manuals, test items, scoring keys or algorithms, and any other materials considered secure by the test developer or publisher.

The term *test data* also refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data*.

GROUP PSYCHOTHERAPY SERVICES

Group psychotherapy treatment is authorized on a case-by-case basis only. If authorized, the worker may participate in group therapy as part of the individual treatment plan. The insurer doesn't pay a group rate to providers who conduct psychotherapy exclusively for groups of workers.

If group psychotherapy is authorized and performed on the same day as individual insight oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions.

NARCOSYNTHESIS AND ELECTROCONVULSIVE THERAPY

CPT® codes 90865 and 90870 require **prior authorization**. Authorized services are payable only to psychiatrists.

OTHER MEDICINE SERVICES

BIOFEEDBACK

Biofeedback treatment requires an attending provider's order and **prior authorization**. Refer to WAC 296-20-03001 for information on what to include when requesting authorization.

Home biofeedback device rentals are time limited and require **prior authorization**. Refer to WAC 296-20-1102 for the insurers' policy on rental equipment.

Biofeedback treatment is limited to those procedures within the scope of practice of the licensed and approved biofeedback provider administering the service.

WAC 296-21-280 limits provision of biofeedback to those who are either certified by the Biofeedback Certification Institute of America (BCIA) or who meet the certification requirements. The WAC also has authorization conditions, treatment limitations and reporting requirements for biofeedback services.

A qualified or certified biofeedback provider as defined in WAC 296-21-280 who isn't licensed as a practitioner as defined in WAC 296-20-01002, may not receive direct payment for biofeedback services. Services may be provided by paraprofessionals as defined in WAC 296-20-015 under the direct supervision of a qualified, licensed practitioner whose scope of practice includes biofeedback and who is BCIA certified or who meets the certification qualifications. The supervising licensed practitioner must bill the biofeedback services.

When biofeedback is performed along with individual psychotherapy:

Bill using either CPT® code 90875 or 90876.

Don't bill CPT® codes 90901 or 90911 with the individual psychotherapy codes.

The following contains the biofeedback codes for approved providers:

CPT®/HCPCS Code	Payable to:
90875	L&I approved biofeedback providers who are: clinical psychologists or psychiatrists (MD or DO).
90876	
90901(1)	Any L&I approved biofeedback provider
90911(1)	
E0746	DME or pharmacy providers (for rental or purchase). Use of the device in the office isn't separately payable for RBRVS providers.

(1) CPT® codes 90901 and 90911 are not time limited and only 1 unit of service per day is payable, regardless of the length of the biofeedback session or number of modalities. Use evaluation and management codes for diagnostic evaluation services.

ELECTRODIAGNOSTIC SERVICES

Covered electrodiagnostic testing services

The department or self-insurer **does cover** use of electrodiagnostic testing including nerve conduction studies and needle electromyography only when:

- Proper and necessary and
- Testing meets the requirements described in this policy.

Billing of electrodiagnostic medicine codes must be in accordance with CPT® code definitions and supervision levels. For the complete requirements for appropriate electrodiagnostic testing see http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/electrodiagnostictesting.asp.

Billing of the technical and professional portions of the codes may be separated. However, the physician billing for interpretation and diagnosis (professional component) must have direct contact with the patient at the time of testing.

Physical therapists (PTs) who meet the requirements of Department of Health rules (WAC 246-915-370) may provide electroneuromyographic tests. PTs performing electrodiagnostic testing must provide documentation of proper DOH licensure to L&I Provider Accounts prior to performing and billing for these services. PT providers may bill for the technical and professional portion of the nerve conduction and electromyography tests performed. Please contact L&I Provider Accounts at (360) 902-5140 for information on where to send proper license documentation.

Performance and billing of NCS (including SSEP and H-reflex testing) and EMG that consistently falls outside of the AANEM recommended number of tests (see Table) may be reviewed for quality and 'proper and necessary'.

The department may recoup payments made to a provider, plus interest, for NCS and EMG tests paid inappropriately.

The table below was developed by the AANEM and summarizes reasonable limits on units required, per diagnostic category, to determine a diagnosis 90% of the time. Review of the quality and appropriateness (proper and necessary) may occur when testing repeatedly exceeds AANEM recommendations.

Recommended Maximum Number of Studies by Indication (adapted from AANEM Table 1).

	Needle EMG CPT® 95860-95864, 95867-95870	**NCS CPT® 95900, 95903, 95904**	**Other EMG studies CPT® 95934, 95936, 95937**		
Indication	# of tests	Motor NCS with and without F-wave	Sensory NCS	H-Reflex	Neuromuscular Junction Testing (repetitive stimulation)
Carpal tunnel (unilateral)	1	3	4		
Carpal tunnel (bilateral)	2	4	6		
Radiculopathy	2	3	2	2	
Mononeuropathy	1	3	3	2	
Poly/mononeuropathy multiplex	3	4	4	2	
Myopathy	2	2	2		2
Motor neuronopathy (eg, ALS)	4	4	2		2
Plexopathy	2	4	6	2	
Neuromuscular Junction	2	2	2		3
Tarsal tunnel (unilateral)	1	4	4		
Tarsal tunnel (bilateral)	2	5	6		

Weakness, fatigue, cramps, or twitching (focal)	2	3	4		2
Weakness, fatigue, cramps, or twitching (general)	4	4	4		2
Pain, numbness or tingling (unilateral)	1	3	4	2	
Pain, numbness or tingling (bilateral)	2	4	6	2	

*Table recreated with written permission from the AANEM.

Non-covered electrodiagnostic testing services

- Testing which isn't proper and necessary per WAC 296-20-01002.
  In general, repetitive testing isn't considered proper and necessary except:
  - To document ongoing nerve injury, for example following surgery
  - If required for provision of an impairment rating
  - To document significant changes in clinical condition
- Testing by mobile diagnostic labs, in which the specialist physician isn't present to examine and test the patient.
- Testing with non-covered devices including portable, automated and 'virtual' devices not demonstrated equivalent to traditional lab-based equipment (eg, NC-stat®, Brevio).
- Testing determined to be outside of AANEM recommended guidelines without proper documentation supporting that it is proper and necessary.
-

ELECTROCARDIOGRAMS (EKG)

Separate payment is allowed for electrocardiograms (CPT® codes 93000, 93010, 93040 and 93042) when an interpretation and report is included.

These services may be paid along with office services. EKG tracings without interpretation and report (CPT® codes 93005 and 93041) are **not payable with** office services.

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code R0076) is bundled into the EKG procedure and isn't **separately payable**.

EXTRACORPOREAL SHOCKWAVE THERAPY (ESWT)

The insurer **doesn't cover** extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature. Additional information can be found at

http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/default.asp#s

VENTILATOR MANAGEMENT SERVICES

The insurer **doesn't pay** for ventilator management services (CPT® codes 94002-94005, 94660 and 94662) when an E/M service (CPT® codes 99201-99499) is reported on the same day by the same provider.

The insurer **pays** for either the ventilation management code or the E/M service, but not both. If a provider bills a ventilator management code and an E/M service for the same day, payment will be made for the E/M service and not for the ventilator management code.

MEDICATION ADMINISTRATION

Immunizations

See WAC 296-20-03005 for work-related exposure to an infectious disease. Immunization materials are payable when authorized.

CPT® codes 90471 and 90472 **are payable** in addition to the immunization materials code(s).

Add-on CPT® code 90472 may be billed for each additional immunization given.

An E/M code **isn't payable** in addition to the immunization administration service, unless it is performed for a separately identifiable purpose and billed with a –25 modifier.

Information on bloodborne pathogens can be found at http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Bloodbornepathogens.asp

Immunotherapy

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. Complete service codes **are not paid**. The provider bills 1 of the injection codes and 1 of the antigen/antigen preparation codes.

Infusion Therapy Services and Supplies for RBRVS Providers

Prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic or home, regardless of who performs the service.

> **Exception:** Outpatient services are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. In these situations, services (CPT® codes 96360, 96361, 96365-96368) **are payable** to physicians, ARNPs, and PAs.
>
> Intravenous or intra-arterial therapeutic or diagnostic injection codes (CPT® codes 96373 and 96374) **won't be paid separately** in conjunction with the IV infusion codes.
>
> Durable Medical Equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers.

Refer to the Home Infusion Services section, page **134** for further information on home infusion therapy.

Providers will be paid for E/M office visits in conjunction with infusion therapy only if the services provided meet the code definitions.

Billing instructions for nonpharmacy providers are located in Injectable Medications, page **93** later in this section. Drugs supplied by a pharmacy must be billed on pharmacy forms with national drug codes (NDCs or UPCs if no NDC is available).

Infusion therapy supplies and related durable medical equipment such as infusion pumps are not separately payable for RBRVS providers. Payment for these items is bundled into the fee for the professional service.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the Home Health Services section, page **130** for further information.

The insurer **may cover** with **prior authorization:**

- Implantable infusion pumps and supplies (HCPCS codes A4220, E0782, E0783, E0785 and E0786).
- The implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal.
- Antispasticity medications by any indicated route of administration when spinal cord injury is an accepted condition (for example, some benzodiazepines, Baclofen).

Placement of nonimplantable epidural or subarachnoid catheters for single or continuous injection of medications **is covered**.

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material are **not covered** (see WAC 296-20-03002).

Infusion of any opiates and their derivatives (natural, synthetic or semisynthetic) are **not covered unless** they are part of providing anesthesia, short term post operative pain management (up to 48 hours post discharge), or unless medically necessary in emergency situations (see WAC 296-20-03014).

Therapeutic or Diagnostic Injections

Professional services associated with therapeutic or diagnostic injections (CPT® code 96372) **are payable** along with the appropriate HCPCS **J** code for the drug.

E/M office visit services provided on the same day as an injection **may be payable** if the services are separately identifiable.

Separate E/M services (CPT® codes 99212-99215) **must be billed** using a –25 modifier.

CPT® code 99211 w**on't be paid** separately and, if billed with the injection code, providers will be **paid only** the E/M service and the appropriate HCPCS **J** code for the drug.

Providers must document the following in the medical record and in the remarks section of the bill:

- Name,
- Strength,
- Dosage and
- Quantity of the drugs administered

Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes 96373 and 96374) may be billed separately and **are payable** if they are not provided in conjunction with IV infusion therapy services (CPT® codes 96360, 96361, 96365-96368).

> **NOTE***:* Injections of narcotics or analgesics **aren't** ***permitted*** or paid in the outpatient setting except:
>
> - On an emergency basis (see WAC 296-20-03014)
> - For pain management related to outpatient surgical procedures and dressing and cast changes
> - For severe soft tissue injuries, burns or fractures.

Dry needling is considered a variant of trigger point injections with medications.

Dry needling is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. Dry needling of trigger points must be billed using CPT® codes 20552 and 20553. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).

The insurer **doesn't cover** acupuncture services (see WAC 296-20-03002). Additional coverage decision information can be found at http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Acupuncture.asp

Injectable Medications

Providers must use the **J** codes for injectable drugs that are administered during an E/M office visit or other procedure. The **J** codes are not intended for self-administered medications.

Miscellaneous Injectable Medication

When billing for a non-specific injectable drug the following must be noted on the bill and documented in the medical record:

- Name,
- Strength,
- Dosage and
- Quantity of drug administered or dispensed.

Distinct Injectable Medication

Although L&I's maximum fees for injectable medications are based on a percentage of AWP and the drug strengths listed in the HCPCS manual, providers must bill their acquisition cost for the drugs. Divide the total strength of the injected drug by the strength listed in the manual to get the total billable units.

For example:

- You administer a 100 mg injection.
- The HCPCS manual lists the strength as 10 mg.
- Your billable units are 100 mg (administered) divided by 10 mg (strength) = 10 units

Payment is made according to the published fee schedule amount, or the acquisition cost for the **covered** drug(s), whichever is less.

Hyaluronic Acid for Osteoarthritis of the Knee

Hyaluronic acid injections are **only allowed** for osteoarthritis of the knee. Other uses are considered experimental, and therefore won't be paid, see WAC 296-20-03002(6).

Hyaluronic acid injections must be billed with CPT® code 20610 and the appropriate HCPCS code.

HCPCS Code	Description	Maximum Fee
J7321	Hyalgan or Supartz inj	$131.20
J7323	Euflexxa, inj	$185.45
J7324	Orthovisc, inj	$243.00
J7325	Synvisc or Synvisc-1, per mg	$ 15.84

The correct side of body modifier (–RT or –LT) is required for authorization and billing. If bilateral procedures are required, both modifiers must be authorized and each billed as a separate line item.

See more information on hyaluronic acid injections at http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/hyaluronicacid.asp

Non-Injectable Medications

Providers may use distinct **J** codes that describe specific noninjectable medication administered during office procedures. Separate payment will be made for medications with distinct J codes. The name, strength, dosage and quantity of the drug administered must be documented in the medical record and noted on the bill. Providers must bill their acquisition cost for these drugs. See the Acquisition Cost Policy in the Supplies, Materials and Bundled Services section, page **135** for more information. No payment will be made for pharmaceutical samples.

The **J** codes aren't intended for self-administered medications.

Miscellaneous oral or noninjectable medications administered during office procedures are considered bundled in the office visit. No separate payment will be made for these medications. The name, strength, dosage and quantity of drug administered or dispensed must be documented in the medical record.

The non-specific HCPCS codes listed below are bundled in the office visit.

HCPCS Code	Brief Description
A9150	Nonprescription drug
J3535	Metered dose inhaler drug
J7599	Immunosuppressive drug, noc
J7699	Noninhalation drug for DME
J8498	Antiemetic drug, rectal/suppository, nos
J8499	Oral prescript drug nonchemo
J8597	Antiemetic drug, oral, nos
J8999	Oral prescription drug chemo

No payment will be made for pharmaceutical samples.

OBESITY TREATMENT

Obesity doesn't meet the definition of an industrial injury or occupational disease.

Temporary treatment may be allowed when the unrelated obesity condition hinders recovery from an accepted condition.

Services for all obesity treatment **require prior authorization**.

To be eligible for obesity treatment, the worker must be severely obese. Severe obesity for the purposes of providing obesity treatment is defined by L&I as a Body Mass Index (BMI) of 35 or greater.

The attending provider may request a weight reduction program if the worker meets all of the following criteria:

- Is severely obese; and
- Obesity is the primary condition retarding recovery from the accepted condition; and
- The weight reduction is necessary to:
  - Undergo required surgery, or
  - Participate in physical rehabilitation, or
  - Return to work.

An attending provider who believes a worker may qualify for obesity treatment should contact the insurer. The attending provider will need to advise the insurer of the worker's weight and level of function prior to the injury and how it has changed.

The attending provider must submit medical justification for obesity treatment, including tests, consultations or diagnostic studies that support the request.

The attending provider may request a consultation with a certified dietitian (CD) to determine if an obesity treatment program is appropriate for the worker.

Only CDs will be paid for nutrition counseling services. CDs may bill for authorized services using CPT® code 97802 or 97803. Both CPT® 97802 and 97803 are billed in 15 minute units.

CPT® Code	Limit	Maximum Fee per unit
97802	Initial visit, maximum of 4 units	$ 52.02
97803	Maximum 2 units per visit with maximum of 3 visits	$ 45.38

Providers practicing in another state that are similarly certified or licensed may apply to be considered for payment.

Prior to authorizing an obesity treatment program, the attending provider and worker are required to develop a treatment plan and sign an authorization letter. This authorization letter will serve as a memorandum of understanding between the insurer, the worker and the attending provider. The treatment plan will include:

- The amount of weight the worker must lose to undergo surgery.
- Estimated length of time needed for the worker to lose the weight.
- A diet and exercise plan, including a weight loss goal, approved by the attending provider as safe for the worker.
- Specific program or other weight loss method requested.
- The attending provider's plan for monitoring weight loss.
- Documented weekly weigh-ins.
- Group support facilitated by trained staff.
- Counseling and education provided by trained staff.
- No requirements to buy supplements or special foods.

The insurer doesn't pay for:

- Surgical treatments of obesity (for example, gastric stapling or jaw wiring).
- Drugs or medications used primarily to assist in weight loss.
- Special foods (including liquid diets).
- Supplements or vitamins.
- Educational material (such as food content guides and cookbooks).
- Food scales or bath scales.
- Exercise programs or exercise equipment.

Upon approval of the obesity treatment plan, the attending provider's role is to:

- Examine the worker, monitor and document their weight loss every 30 days.
- Notify the insurer when:
  - The worker reaches the weight loss goal, or
  - Obesity no longer interferes with recovery from accepted condition, or
  - The worker is no longer losing the weight needed to meet the weight loss goal in the treatment plan.

To ensure continued authorization of the obesity treatment plan the worker must do each of the following:

- Lose **an average** of 1 to 2 pounds a week.
- Regularly attend weekly treatment sessions (meetings and weigh-ins).
- Cooperate with the approved obesity treatment plan.
- Be evaluated by the attending doctor at least every 30 days.
- Pay the joining fee and weekly membership fees up front and get reimbursed.

Send the insurer a copy of the weekly weigh-in sheet signed by the program coordinator every week.

The insurer doesn't pay the obesity treatment provider directly. The worker will be reimbursed for the obesity treatment program using the following codes:

Code	Description	Fee Limits
0440A	Weight loss program, joining fee, worker reimbursement	$154.77
0441A	Weight loss program, weekly fee, worker reimbursement	$30.96

The insurer authorizes obesity treatment for up to 90 days at a time as long as the worker does **all** of the above. The insurer stops authorizing obesity treatment when **any one** of the following occurs:

- The worker reaches the weight loss goal identified in the obesity treatment plan. (The worker may continue the weight loss program for general health at their own expense).
- Obesity no longer interferes with recovery from the accepted condition. (WAC 296-20-055 prohibits treatment of an unrelated condition once it no longer retards recovery from the accepted condition.)
- The worker isn't cooperating with the approved obesity treatment plan.
- The worker isn't losing weight at **an average** of 1 to 2 pounds each week.

IMPAIRMENT RATING EXAMINATION AND REPORT BY ATTENDING DOCTORS AND CONSULTANTS

Qualified attending providers (AP) may rate impairment of their own patients per WAC 296-20-2010. See table below to determine if you are qualified to provide this service.

Impairment rating should occur during the closing exam. Include the objective findings to support the impairment rating. The objective medical information will also be needed if a worker requests the claim be reopened.

The AP can ask a consultant to perform the rating examination if the AP is unable or unwilling to perform the rating examination.

APs: See billing codes 1190M, 1191M and 1192M below.

Consultants: See billing codes 1194M and 1195M below.

Which providers may rate impairment?

Provider type - currently licensed in	Able to rate impairment as AP or consultant?
Medicine and surgery	Yes
Osteopathic medicine and surgery	Yes
Podiatric medicine and surgery	Yes
Dentistry	Yes
Chiropractic	Yes, if L&I approved IME examiner
Naturopathy	No
Optometry	No
Physicians' Assistant	No
Advanced Registered Nurse Practitioners (ARNP), including Psychiatric ARNPs	No

Providers may only give ratings for areas of the body or conditions within their scopes of practice.

- Psychologists may not be an attending provider (except for Crime Victim's claims) and may not rate impairment for injured workers or victims of crime.
- Chiropractors performing impairment ratings must be on L&I's list of approved IME examiners.

For details on this topic, refer to the Medical Examiners' Handbook. To view a copy online go to http://www.Lni.wa.gov/IPUB/252-001-000.pdf

Attending providers who are permitted to rate their own patients don't need an IME provider account number and may use their existing provider account number.

For details on this topic, refer to the Attending Doctor's Handbook. To view a copy online go to http://www.Lni.wa.gov/IPUB/252-004-000.pdf

When do you perform the impairment rating?

Rate impairment when the worker has reached maximum medical improvement (MMI) or when requested by the insurer.

For what areas of the body do you rate impairment?

Rate impairment for medical conditions accepted under the claim.

Prior authorization is only required when:

- A psychiatric impairment rating is needed.
- An IME is scheduled.
  - For State Fund claims, use our secure, online Claim & Account Center to see if an IME is scheduled. To set up an account go to www.Claiminfo.Lni.wa.gov.
  - For Self-Insured claims, contact the self-insured employer (SIE) or their third party administrator (TPA). For a list of SIE/TPAs, go to: http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp
  - For Crime Victims claims call 1-800-762-3716.

How do you rate impairment?

Use the appropriate rating system.

See the *Medical Examiners' Handbook* for an overview of systems for rating impairment.

Impairment rating reports must include **all** of the following elements:

MMI	Statement that the patient has reached maximum medical improvement (MMI) and that no further curative or rehabilitative treatment is recommended.
Physical Exam	Pertinent details of the physical examination performed (both positive and negative findings).
Diagnostic Tests	Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of any pertinent tests or studies ordered as part of the exam.
Rating	An impairment rating consistent with the findings and a statement of the system on which the rating was based. For example: • **The AMA Guidelines to the Evaluation of Permanent Impairment and the edition used, or** • **The Washington state category rating system – refer to WAC 296-20-19000 through 296-20-19030 and WAC 296-20-200 through 296-20-690, and for amputations refer to RCW 51.32.080.**
Rationale	The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

If there is no impairment, document that in your report. For more details and examples about rating impairment, see the *Medical Examiners' Handbook*.

Use the most appropriate billing code from the following table:

Code	Description	Maximum Fee
1190M	Impairment rating by attending physician, limited, 1 body area or organ system. Use this code if there is only 1 body area or organ system that needs to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements:	$ 439.50

Code	Description	Maximum Fee
	• Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body area or organ system. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed as requested. • Impairment rating report must contain the required elements noted in the ***Medical Examiners' Handbook*****.** Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	
1191M	Impairment rating by attending physician, standard, 2-3 body areas or organ systems. Use this code if there are 2-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body area or organ system. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed as requested. • Impairment rating report must contain the required elements noted in the *Medical Examiners' Handbook*. Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	$ 493.56
1192M	Impairment rating by attending physician, complex, 4 or more body areas or organ systems. Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body area or organ system. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed as requested. • Impairment rating report must contain the required elements noted in the *Medical Examiners' Handbook*. Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	$ 616.93
1194M	Impairment rating by consultant, standard, 1-3 body areas or organ systems. Use this code if there are 1-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Records are reviewed. • Physical exam is directed only toward the affected areas or organ systems of the body. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed as requested. • Impairment rating report must contain the required elements noted in the *Medical Examiners' Handbook*. Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	$ 493.56

Code	Description	Maximum Fee
1195M	Impairment rating by consultant, complex, 4 or more body areas or organ systems. Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Records are reviewed. • Physical exam is directed only toward the affected areas or organ systems of the body. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed as requested. • Impairment rating report must contain the required elements noted in the *Medical Examiners' Handbook*. Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	$ 616.93
1198M	Impairment rating, addendum report. Must be requested and authorized by the claim manager. • Addendum report for additional information which necessitates review of new records. • Payable to attending physician or consultant. This code isn't billable when the impairment rating report did not contain all the required elements. (See the *Medical Examiners' Handbook* for the required elements.)	$ 113.40

Limited, Standard and Complex Coding

The impairment rating exam should be sufficient to achieve the purpose and reason the exam was requested. Choose the code based on the number of body areas or organ systems that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related. Be sure the report documents the relationship of the areas examined to the accepted or contended conditions.

The definitions of body areas and organ systems from Current Procedural Terminology (CPT®) book must be used to distinguish between limited, standard and complex impairment rating.

The following **body areas** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttock
- Back
- Each extremity

The following **organ systems** are recognized:

- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Gastrointestinal
- Respiratory
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

NOTE: Each extremity is counted once per extremity examined, when determining limited, standard or complex codes. For example, in a case of bilateral carpal tunnel syndrome, if both right and left extremities are examined, 2 body areas would be counted.

INDEPENDENT MEDICAL EXAMINATIONS (IME)

Limit on Total Scheduled Exams per Day

L&I has placed a limit of 12 independent medical examinations scheduled per examiner per day. This limit is inclusive of IMEs scheduled for State Fund and self-insured claims. The applicable codes include:

- 1108M IME, standard exam – 1-3 body areas or organ systems
- 1109M IME, complex exam – 4 or more body areas or organ systems
- 1111M IME, no-show fee, per examiner
- 1112M IME, additional examiner for IME
- 1118M IME by psychiatrist
- 1120M IME, no-show fee, psychiatrist
- 1122M Impairment rating by an approved pain program
- 1130M IME, terminated exam
- 1131M IME, out-of-state exam
- 1134M, Late cancellation fee
- 1135M, Late cancellation fee, psychiatrist
- 1136M, IME, two claims included in evaluation
- 1137M, IME, three claims included in evaluation
- 1138M, IME four or more claims included in evaluation

IME Unique Billing Codes

Code	Description	Maximum Fee
1100M	IME, microfiche handling, initial 10 pages of fiche with referral. • Payable only once per referral. • You may not bill this code if you are provided with a paper copy of the claim record.	$ 58.82
1101M	IME, microfiche handling, per fiche page beyond 10 • 1 unit equals 1 microfiche page. • Use code with associated units only once per referral.	$ 5.89 (per fiche page)
1104M	IME, addendum report. Requested and authorized by claim manager. • Addendum report for information not requested in original assignment, which necessitates review of records. • Not to be used for review of job analysis or review of diagnostic testing or study results ordered by the examiner.	$ 113.40
1105M	IME Physical Capacities Estimate. Must be requested by the insurer. Bill under lead examiner's provider account number for multi-examiner exams	$ 30.27

Code	Description	Maximum Fee
1108M	IME, standard exam – 1-3 body areas or organ systems • Use this code if there are only 1-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). • An appropriate exam and reporting of an injury or condition limited to 1-3 body areas or organ systems. • Records are reviewed and the report includes a detailed chronology of the injury or condition as described in the *Medical Examiners' Handbook*. • Physical exam is directed only toward the affected body areas or organ systems. • Diagnostic tests needed are ordered and interpreted. Impairment rating is performed if requested. • The IME report must contain the required elements noted in the *Medical Examiners' Handbook*. • The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • Includes review of up to 2 job analyses. • L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the patient. • This code can be used by: Single examiners, leads on multi-examiner exams where findings from other examiners are combined into 1 report, & examiners on multi-examiner exams who perform separate file review, exam and standalone reports. Additional examiners who are not leads: Use 1112M. **	$ 493.56
1109M	IME, complex exam – 4 or more body areas or organ systems • Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). • An appropriate exam and reporting of an injury or condition of 4 or more body areas or organ systems. • Records are reviewed and the report includes a detailed chronology of the injury or condition, as described in the *Medical Examiners' Handbook*. • Physical exam is directed only toward the affected body areas or organ systems. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed if requested. • The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • The IME report must contain the required elements noted in the *Medical Examiners' Handbook*. • Includes review of up to 2 job analyses. • L&I expects that these exams will typically involve at least 45 minutes of face-to-face time with the patient. • This code can be used by: Single examiners, leads on multi-examiner exams where findings from other examiners are combined into 1 report, & examiners on multi-examiner exams who perform separate file review, exam and standalone reports. Additional examiners who are not leads: Use 1112M. **	$ 616.93
1111M	IME, no-show fee, per examiner. • Bill only if appointment time cannot be filled • Not payable for no-shows of IME related services (for example, neuropsychological evaluations, performance based PCEs). WAC 296-20-010	$ 210.03
1134M	IME late cancellation fee, per examiner • Bill only if appointment time cannot be filled and cancellation is within 3 business days of exam. Business days are Monday thru Friday. • Not payable for no-shows of IME related services (for example, neuropsychological evaluations).	$ 210.03

1112M	IME, additional examiner for IME
	• Use where input from more that 1 examiner is combined into 1 report. Includes:
	  • Record review,
	  • Exam, and
	  • Contribution to combined report
	  • L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the patient.
	Note: Lead examiner on IMEs with a combined report should bill a standard or complex exam code (1108M or 1109M).
		$ 439.50

Code	Description	Maximum Fee
1118M	IME by psychiatrist • Psychiatric diagnostic interview with or without direct observation of a physical exam. • Includes review of records, other specialist's exam results, if any • Consultation with other examiners and submission of a joint report if scheduled as part of a panel. • Report includes a detailed chronology of the injury or condition, as described in the Medical Examiners' Handbook. • L&I expects that these exams will typically involve at least 60 minutes of face-to-face time with the patient. • Also includes impairment rating, if applicable.	$ 893.15
1120M	IME, no-show fee, psychiatrist • Bill only if appointment time cannot be filled • Not payable for no-shows of IME related services (for example, neuropsychological evaluations). WAC 296-20-010	$ 325.56
1135M	IME late cancellation fee, psychiatrist • Bill only if appointment time cannot be filled and cancellation is within 3 business days of exam. Business days are Monday thru Friday. • Not payable for no-shows of IME related services (for example, neuropsychological evaluations).	$ 325.56

1122M	Impairment rating by an approved pain program
	• Program must be approved by insurer
	• Impairment rating must be requested by the insurer.
	• Must be performed by a doctor currently licensed in medicine and surgery (including osteopathic and podiatric physicians), dentistry, or L&I approved chiropractic examiners. See WAC 296-20-2010.
	• The rating report must include at least the following elements as described in the Medical Examiners' Handbook:
	  • MMI (maximum medical improvement)
	  • Physical exam
	  • Diagnostic tests
	  • Rating
	  • Rationale
		$ 493.56

1123M	IME, communication issues • Exam was unusually difficult due to expressive problems, such as a stutter, aphasia or need for an interpreter in a case that required an extensive history as described in the report. • If interpreter needed, verify and record name of interpreter in report. • Bill once per examiner per exam. • Not payable with a no-show fee (1111M or 1120M).	$ 198.48
1124M	IME, other, by report • Requires preauthorization and prepay review. For State Fund claims call Provider Review and Education at 360-902-6818. For self-insured claims contact the self-insured employer or third party administrator.	By Report

Code	Description	Maximum Fee
1125M	Physician travel per mile • Allowed when roundtrip exceeds 14 miles. Code usage is limited to extremely rare circumstances. • Requires preauthorization and prepay review. For State Fund claims call Provider Review and Education at 360-902-6818. For self-insured claims contact the self-insured employer or third party administrator.	$ 4.84
1128M	Occupational disease history. • Must be requested by insurer. • Occupational carpal tunnel syndrome, noise-induced hearing loss, occupational dermatitis, and occupational asthma are examples of conditions which L&I considers occupational diseases. • The legal standard is different for occupational diseases than for occupational injuries. • This is a detailed assessment of work-relatedness, with the exact content presented in the Medical Examiners' Handbook. • A doctor may bill this code ONLY ONCE for each patient.	$ 183.56

1129M	IME, extensive file review by examiner
	• Units of service are based on the number of hardcopy pages reviewed by the IME examiner on microfiche, paper, Claim and Account Center or other medium.
	• Review of the first 550 hardcopy pages is included in the base exam fee (1108M, 1109M, 1118M or 1130M).Bill for each additional page reviewed beyond the first 550 hardcopy pages.
	• Not payable with 1111M or 1120M.
	• Only the following document categories will be paid for unless the authorizing letter requests a review of ALL documents:
	  • Medical files
	  • History
	  • Report of Accident
	  • Re-open Application
	  • Other documents specified by claim manager or requestor
	• Bill per examiner
	• Bill for unique documents not duplicates. Payment will not be made for review of duplicate documents.
	NOTE: To be eligible for payment, a detailed chronology of the injury or condition must be included in the report as defined by the Medical Examiners' Handbook.
		$ 1.00

1130M	IME, terminated exam • Bill for exam ended prior to completion. • Requires file review, partial exam and report (including reasons for early termination of exam).	$ 351.59
1131M	IME, out-of-state exam	by report

1132M	• Document printing of electronic medical records per page.
	• Payable only once per IME referral.
	• Charges must be based on printing the following electronic records unless the authorizing letter requests a review of ALL documents:
	  • Report of Accident
	  • Re-open application
	  • History
	  • Medical files
	  • Other documents specified by claim manager or requestor
	NOTE: This fee isn't payable if paper copies of records are provided.
		$ 0.07 per printed page

Code	Description	Maximum Fee
1133M	IME, document processing fee. Payable only once per IME referral. **NOTE**: This fee includes the preparation of documents for examiner review. The preparation of documents includes duplicate document removal.	$ 58.82
1139M	IME, no show fee for missed neuropsychological testing. • Must be scheduled or approved by department or self-insurer as part of an independent medical examination. Authority: WAC 296-20-010(5). • This code is payable only once per independent medical examination assignment. • Must notify department or self-insurer of no-show as soon as possible. • Bill only if appointment cannot be filled.	$882.56
1140M	IME, no show fee for missed PCE. • Must be scheduled or approved by department or self-insurer as part of an independent medical examination. Authority: WAC 296-20-010(5). • This code is payable only once per independent medical examination assignment. • Must notify department or self-insurer of no-show as soon as possible. • Bill only if appointment cannot be filled.	$282.31
Modifier -7N	X-rays and laboratory services in conjunction with an IME. • When X-rays, laboratory and other diagnostic tests are provided with an exam, identify the service(s) by adding the modifier – 7N to the usual procedure number. Procedure codes are listed in the L&I Fee Schedules, Radiology and Laboratory Sections.	N/A

Multiple Claim Codes

1136M	IME, Two claims included in evaluation. • Medical examination includes second claim to be evaluated by the medical examiner. This code is used in addition to the primary IME exam code (1108M, 1109M, 1112M, 1118M, or 1130M) only. This should not be reported as a stand-alone code. • Bill once per examiner. **NOTE:** This must be pre-authorized by state fund claim manager or self-insured employer/third party administrator.	$100.00
1137M	IME, Three claims included in evaluation. • Medical examination includes second and third claims to be evaluated by the medical examiner. This code is used in addition to the primary IME exam code (1108M, 1109M, 1112M, 1118M, or 1130M) only. This should not be reported as a stand-alone code. • Bill once per examiner. **NOTE:** This must be pre-authorized by state fund claim manager or self-insured employer/third party administrator.	$200.00
1138M	IME, Four or more claims included in evaluation. • Medical examination includes second, third, and four or more claims to be evaluated by the medical examiner. This code is used in addition to the primary IME exam code (1108M, 1109M, 1112M, 1118M, or 1130M) only. This should not be reported as a stand-alone code. • Bill once per examiner. **NOTE:** This must be pre-authorized by state fund claim manager or self-insured employer/third party administrator.	$300.00

Billing State Fund (L&I) for In-State IMEs

For IMEs performed in Washington State, examiners need 1 IME provider account number for each payee they wish to designate.

An IME examiner not working through any IME firms will need just 1 IME number, which will also serve as their payee number.

HOW IME FIRMS MUST BILL FOR IMES CONDUCTED IN WASHINGTON STATE

The chart below shows which provider account number and/or National Provider Identifier (NPI) to use in 24J of the CMS 1500 form based on the IME service provided. The NPI must be registered with the department.

Use only the IME examiner's provider account number/NPI for these codes:		**Use only the IME firm provider account number/NPI for these codes:**	**The following codes may be billed by the IME examiner, the IME firm, or by the performing provider.**
1028M	1118M	1100M	1124M
1038M	1120M	1101M	CPT® Code 90801
1048M	1123M	1132M	CPT® Codes 96101, 96102
1066M	1125M	1133M	CPT® Codes 96118, 96119
1104M 1105M	1128M		X-ray, diagnostic laboratory tests in conjunction with IME (Use modifier -7N.)
1108M	1129M		1045M
1109M	1130M		
1111M 1112M 1134M 1135M 1136M 1137M 1138M	CPT® Codes 99441-99443		

NOTE: On CMS-1500, IME firms may use their own provider account number (box 33b) and/or NPI (box 33a) as the "payee" although it isn't required if the same provider account number /NPI is in box 24J.

Billing for Out-of-State IMEs

A separate provider account number is required for IMEs conducted outside of Washington State.

IME examiners must meet L&I's criteria for approved examiners.

IME examiners must be approved by L&I. To obtain the procedures and an IME provider application, go to http://www.lni.wa.gov/ClaimsIns/Providers/Becoming/IME/default.asp. When you submit your application include a copy of the doctor's license for the state where the exam will be conducted and current curriculum vitae (CV).

Firms will not be required to put the examiner provider account number on State Fund bills.

Bills for out-of-state IMEs must contain the IME firm's provider account number in box 33b of the CMS-1500 bill form.

Bill your usual and customary fees.

Use billing code 1131M for all services, **except** 1100M and 1101M, and the CPT® codes for neuropsychological evaluation and testing. Combine all 1131M charges into one line-item on your bill. Also use 1131M for activities occurring after the IME, such as addendums.

L&I and self insurers will reimburse 1131M by report.

Standard and Complex Coding

The exam should be sufficient to achieve the purpose and reason the exam was requested. Choose the code based on the number of body areas or organ systems that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related. Be sure the report documents the relationship of the areas examined to the accepted or contended conditions.

The definitions of body areas and organ systems from the Current Procedural Terminology (CPT®) book must be used to distinguish between standard and complex IMEs.

The following **body areas** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttock
- Back
- Each extremity

The following **organ systems** are recognized:

- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Respiratory
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

NOTE: Each extremity is counted once per extremity examined, when determining standard or complex codes. For example, in a case of bilateral carpal tunnel syndrome, if both right and left extremities are examined, 2 body areas would be counted.

General Information

Only doctors with an IME provider account number can bill IME codes. To obtain an application, go to http://www.Lni.wa.gov/forms/pdf/245046af.pdf

Or, for Crime Victims contact the Crime Victims Compensation Program Provider Registration desk at 360-902-5377.

For more information on becoming an approved IME provider or to perform impairment ratings, please see the *Medical Examiners' Handbook* at http://www.Lni.wa.gov/IPUB/252-001-000.pdf

or go to

http://www.lni.wa.gov/ClaimsIns/Providers/Becoming/IME/default.asp

To receive e-mail updates on IMEs, subscribe to the ListServ at
http://www.Lni.wa.gov/Main/Listservs/IME.asp

NATUROPATHIC PHYSICIANS

Naturopathic physicians should use the local codes listed in this section to bill for office visit services, CPT® codes 99367 and 99441-99444 to bill case management services and the appropriate HCPCS codes to bill for miscellaneous materials and supplies.

Refer to Case Management Services, page **40** in the Evaluation and Management section for payment criteria and documentation requirements for case management services.

The department will not pay naturopathic physicians for services that are not specifically allowed including consultations. Refer to WAC 296-23-205 and 296-23-215 for additional information.

INITIAL VISITS

2130A	Routine examination, history, and/or treatment (routine procedure), and submission of a report	$51.50
2131A	Extended office visit including treatment – report required	$77.26
2132A	Comprehensive office visit including treatment – report required in addition to the report of accident	$103.03

FOLLOW-UP VISITS

2133A	Routine office visit including evaluation and/or treatment	$41.22
2134A	Extended office visit including treatment – report required	$77.26

PATHOLOGY AND LABORATORY SERVICES

PANEL TESTS

Automated Multichannel Tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both.

The following tests are automated multichannel tests or panels comprised solely of automated multichannel tests:

CPT® codes								
80048	80069	82247	82374	82550	82977	84100	84295	84478
80051	80076	82248	82435	82565	83615	84132	84450	84520
80053	82040	82310	82465	82947	84075	84155	84460	84550

Calculating Payment for Automated Tests

The automated individual and panel tests above are paid based on the total number of unduplicated automated multichannel tests performed per day per patient. Calculate the payment according to the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined;
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day;
- Any duplicated tests are denied;
- The total number of remaining unduplicated automated tests is counted.

See the following table to determine the payable fee based on the total number of unduplicated automated tests performed.

Number of Tests		Fee
1	Test	Lower of the single test or $10.26
2	Tests	$10.26
3 –12	Tests	$12.59
13 –16	Tests	$16.81

Number of Tests		Fee
17 – 18	Tests	$18.83
19	Tests	$21.80
20	Tests	$22.48
21	Tests	$23.20
22 –23	Tests	$23.91

Calculating Payment for Panels with Automated and NonAutomated Tests

When panels are comprised of both automated multichannel tests and individual nonautomated tests, they are priced based on:

- The automated multichannel test fee based on the number of tests, added to
- The sum of the fee(s) for the individual nonautomated test(s).

For example CPT® code 80061 is comprised of 2 automated multichannel tests and 1 non-automated test. As shown below, the fee for 80061 is **$27.31.**

CPT® 80061 Component Tests	Number of Automated Tests	Maximum Fee
Automated: CPT® 82465 CPT® 84478	2	Automated: $ 10.26
Nonautomated: CPT® 83718	N/A	Nonautomated: $ 16.13
	Maximum Payment:	$ 26.39

Calculating Payment for Multiple Panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be limited to the total fee allowed for the unduplicated component tests.

Example:

The table below shows how to calculate the maximum payment when panel codes 80050, 80061 and 80076 are billed with individual test codes 82977, 83615, 84439 and 85025.

Test	CPT® PANEL CODES			INDIVIDUAL TESTS	Test Count	Max Fee
	80050	80061	80076			
Automated Tests	82040 84075 82247 84132 82310 84155 82374 84295 82435 84450 82565 84460 82947 84520	82465 84478	82040(1) 82247(1) 82248 84075(1) 84155(1) 84450(1) 84460(1)	82977 83615	19 Unduplicated Automated Tests	$ 21.80
	84443					$32.98
	85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009					$15.32
		83718				$16.13
				84439		$17.23
Nonautomated Tests				85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009 (1)		$ 0.00
					MAXIMUM PAYMENT:	$ 103.46

(1) DUPLICATED TESTS

DRUG SCREENS

The insurer will pay for drug screening conducted in the office setting by a laboratory with a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver and confirmation testing performed at a laboratory not requiring a CLIA certificate of waiver.

Codes that can be billed

Effective 1/1/2011 the department will pay for drug screening using the following CPT® and HCPCS codes:

- 80100, Drug screen, qualitative; multiple drug classes chromatographic method, each procedure.
- 80102, Drug confirmation, each procedure.
- G0431, Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class.
- G0434, Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter.

Payment limits

- 80100 and 80102 are only payable to laboratories that don't require a CLIA certificate of waiver.
- G0431 is limited to one unit per day per patient encounter for laboratories with a CLIA certificate of waiver. Laboratories that don't require a CLIA certificate of waiver may bill more than one unit per day per patient encounter.
- G0434 is limited to one unit per day per patient encounter regardless of the CLIA status of the laboratory.

Codes that are not covered

Effective 1/1/2011 the following CPT codes are not covered by the insurer:

- 80101
- 80104

REPEAT TESTS

Additional payment is allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) must be taken from separate encounters.

Test(s) normally performed in a series (for example, glucose tolerance tests or repeat testing of abnormal results) don't qualify as separate encounters.

The medical necessity for repeating the test(s) must be documented in the patient's record.

Modifier –91 must be used to identify the repeated test(s). Payment for repeat panel tests or individual components tests will be made based on the methodology described in the Panel Tests section.

SPECIMEN COLLECTION AND HANDLING

Specimen collection charges are allowed as follows:

- The fee is payable only to the provider who actually draws the specimen.
- Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee qualified to do specimen collection performs the draw.
- Payment for performing the test is separate from the specimen collection fee.
- Costs for media, labor and supplies (for example, gloves, slides, antiseptics, etc.) are included in the specimen collection.
- A collection fee isn't allowed when the cost of collecting the specimen(s) is minimal, such as:
  - A throat culture,
  - Pap smear or
  - A routine capillary puncture for clotting or bleeding time.

Specimen collection performed by patients in their homes isn't paid (such as stool sample collection).

Use CPT® code 36415 for venipuncture. Use HCPCS code P9612 or P9615 for catheterization for collection of specimen.

Complex vascular injection procedures, such as arterial punctures and venisections, are not subject to this policy and will be paid with the appropriate CPT® or HCPCS codes.

Travel **won't be paid** to nursing home or skilled nursing facility staff that performs specimen collection.

Travel **will be paid** in addition to the specimen collection fee when **all** of the following conditions are met:

- It is medically necessary for a provider to draw a specimen from a nursing home, skilled nursing facility or homebound patient, and
- The provider personally draws the specimen, and
- The trip is solely for the purpose of collecting the specimen.

If the specimen draw is incidental to other services, no travel is payable.

Use HCPCS code P9603 to bill for actual mileage (1 unit equals 1 mile). HCPCS code P9604 isn't **covered**.

Handling and conveyance **won't be paid**, (for example, shipping or messenger or courier service of specimen(s)). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These are considered to be integral to the process and are bundled into the total fee for testing service.

STAT LAB FEES

Usual laboratory services **are covered** under the Professional Services Fee Schedule.

When lab tests are appropriately performed on a STAT basis, the provider may bill HCPCS code S3600 or S3601. Payment is limited to 1 STAT charge per episode (not once per test).

Tests ordered STAT should be limited to only those needed to manage the patient in a true emergency situation. The laboratory report should contain the name of the provider who ordered the STAT test(s). The medical record must reflect the medical necessity and urgency of the service.

The STAT charge will only be paid with the tests listed below.

CPT® Code	CPT® Code	CPT® Code	CPT® Code
80047	81003	84100	85384
80048	81005	84132	85396
80051	82003	84155	85610
80069	82009	84157	85730
80076	82040	84295	86308
80100	82055	84302	86367
80156	82150	84450	86403
80162	82247	84484	86880
80164	82248	84512	86900
80170	82310	84520	86901
80178	82330	84550	86902
80184	82374	84702	86920
80185	82435	84704	86921
80188	82550	85004	86922
80192	82565	85007	86923
80194	82803	85025	86971
80196	82945	85027	87205
80197	82947	85032	87210
80198	83615	85046	87281
81000	83663	85049	87327
81001	83874	85378	87400
81002	83880	85380	89051

HCPCS Code	Abbreviated Description
G0306	Complete CBC, auto w/diff
G0307	Complete CBC, auto
G0431	Drug screen, single class
G0434	Drug screen, multi drug class

TESTING FOR AND TREATMENT OF BLOODBORNE PATHOGENS

The insurer may pay for post-exposure treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease. Authorization of treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim at a later date.

The exposed worker must apply for benefits (submit an accident report form) before the insurer can pay for testing and treatment.

Covered Testing Protocols

Testing for Hepatitis B, C and HIV should be done at the time of exposure and at 3, 6, and 12 months post exposure. The following test protocols are **covered**:

Hepatitis B (HBV)

- HbsAg (hepatitis B surface antigen).
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen).
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

Hepatitis C (HCV)

- Enzyme Immunoassay (EIA).
- Recombinant Immunoblot Assay (RIBA).
- Strip Immunoblot Assay (SIA).

The qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are **covered** services if HCV is an accepted condition on a claim:

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR).
- Branched-chain DNA (bDNA).
- Genotyping.
- Liver biopsy.

HIV

There are 2 blood tests needed to verify the presence of HIV in blood:

- Rapid HIV or EIA test, and
- A Western Blot test to confirm seropositive status.

The following tests are used to determine the presence of HIV in blood:

- Rapid HIV test.
- EIA test.
- Western Blot test.
- Immunofluorescent antibody.

The following tests are **covered** services if HIV is an accepted condition on a claim:

- HIV antiretroviral drug resistance testing.
- Blood count, kidney, and liver function tests.
- CD4 count.
- Viral load testing.

Post-exposure Prophylaxis for HBV

Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate.

Post-exposure Prophylaxis for HIV

When a possible exposure to HIV occurs, the insurer will pay for chemoprophylaxis treatment in accordance with the most recent Public Health Services (PHS) Guidelines. **Prior authorization isn't required**.

When chemoprophylaxis is administered, the insurer will pay at baseline and periodically during drug treatment for drug toxicity monitoring including:

- Complete blood count and
- Renal and hepatic chemical function tests

Covered Bloodborne Pathogen Treatment Regimens

Chronic hepatitis B (HBV)

- Interferon alfa-2b.
- Lamivudine.

Hepatitis C (HCV) – acute

- Mono therapy.
- Combination therapy.

HIV/AIDS: Covered services are limited to those within the most recent guidelines issued by the HIV/AIDS Treatment Information Service (ATIS). These guidelines are available on the web at http://aidsinfo.nih.gov/.

Treating a Reaction to Testing or Treatment of an Exposure

The insurer will allow a claim and applicable accident fund benefits when a worker has a reaction to **covered** treatment for a probable exposure.

BLOODBORNE PATHOGEN BILLING CODES

Diagnostic Test/Procedure

CPT® Code
47100
83890
83894
83896
83898
83902
83912
86689
86701
86704
86706

CPT® Code
86803
86804
87340
87390
87521
87522
87901
87903
87904

Treatment Related Procedures

CPT® Code
78725
86360
87536
80076
90371
90746 (adult)
90772-90779

CPT® Code
99201-99215
99217-99220

PHARMACY SERVICES

PHARMACY FEE SCHEDULE

This fee schedule applies to pharmacy providers only. It doesn't apply to medical providers administering or dispensing drugs in the office. Payment for drugs and medications, including all oral nonlegend drugs, will be based on the pricing methods described below. Refer to WAC 296-20-01002 for definition of Average Wholesale Price (AWP).

Drug Type	Payment Method
Generic	AWP less 50% (+) $ 4.50 professional fee
Single or multisource brand	AWP less 10% (+) $ 4.50 professional fee
Brand with generic equivalent (Dispense as Written only)	AWP less 10% (+) $ 4.50 professional fee
Compounded prescriptions	Allowed cost of ingredients (+) $4.50 professional fee (+) $4.00 compounding time fee (per 15 minutes)

Orders for over-the-counter nonoral drugs or nondrug items must be written on standard prescription forms. Price these on a 40% margin.

Prescription drugs and oral or topical over-the-counter medications are nontaxable (RCW 82.08.0281).

COVERAGE POLICY

The outpatient formulary can be found in Appendix F, page 258 at the end of this document or at http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/Presc/default.asp

Preferred Drug List

L&I uses a subset of the Washington State Preferred Drug List (PDL). A current list of the drug classes that are part of the workers' compensation benefit and on the PDL is available at http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/PDL.asp.

Endorsing the Preferred Drug List

Providers may endorse the PDL by:

- Registering online at http://www.rx.wa.gov/tip.html or
- Filling out and returning a registration form available at http://www.rx.wa.gov/tip.html or
- By calling Benefit Control Methods at 866-381-7879 or 866-381-7880

Endorsing Practitioner and Therapeutic Interchange Program

Endorsing practitioners may indicate Dispense as Written (DAW) on a prescription for a nonpreferred drug on the PDL and the prescription will be filled as written.

Alternatively, if an endorsing practitioner indicates substitution permitted on a prescription for a nonpreferred drug on the PDL, the pharmacist will interchange a preferred drug for the nonpreferred drug and a notification will be sent to the prescriber.

Therapeutic interchange **won't** occur when the prescription is a refill of an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug as exempted by law. See WAC 296-20-01002 for definitions relating to the Therapeutic Interchange Program:

- Endorsing practitioner
- Refill

- Therapeutic alternative
- Therapeutic interchange

Due to federal regulations, therapeutic interchange will not take place when the prescription is for a schedule II nonpreferred drug. However, L&I will honor the prescription if an endorsing practitioner indicates DAW for a schedule II nonpreferred drug.

> **Exception:** Fentanyl patch (Duragesic) **won't** be routinely covered. For exception criteria see http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Duragesic.asp

COVERAGE FOR BUPRENORPHINE OR BUPRENORPHINE/NALOXONE

The department may cover buprenorphine (Subutex®) or buprenorphine/naloxone (Suboxone®) for a limited time to aid in opioid weaning, but doesn't provide coverage for maintenance of opioid dependency or for off-label uses.

Prior authorization is required for buprenorphine and buprenorphine/naloxone products. The requesting provider must:

- Provide documentation of a time-limited opioid taper plan and
- Have a current DATA 2000 waiver to prescribe buprenorphine and buprenorphine/naloxone.

To verify whether a provider has a valid DATA waiver, use the Buprenorphine Locator at http://buprenorphine.samhsa.gov/bwns_locator/dr_facilitylocatordoc.htm

Authorization is limited to 30 days. An additional 30 days is available if requested and progress on the opioid taper has been documented.

OBTAINING AUTHORIZATION FOR NONPREFERRED DRUGS

The table lists what providers should do to obtain authorization for **nonpreferred** drugs.

Outpatient drug formulary	Endorsing provider	Nonendorsing provider
Preferred Drug List	Write DAW for nonpreferred drugs	Contact the PDL Hotline (888) 443-6798
Remainder of drug classes	Contact the PDL Hotline (888) 443-6798	Contact the PDL Hotline (888) 443-6798

The PDL Hotline is open Monday through Friday 8:00 am to 5:00 pm (Pacific Time).

Filling prescriptions after hours

If a pharmacy receives a prescription for a nonpreferred drug when authorization cannot be obtained, the pharmacist may dispense an emergency supply of the drug by entering a value of 6 in the DAW field. L&I **must authorize** additional coverage for the nonpreferred drug.

> **NOTE**: An emergency supply is typically 72 hours for most drugs or up to 10 days for most antibiotics, depending on the pharmacist's judgment.

Retaining prescriptions

WAC 296-20-02005 (Keeping of records) requires that records must be maintained for audit purposes for a minimum of 5 years.

NCPDP V5.1 PAYER SHEET

L&I uses version 5.1 of the NCPDP payer sheet to process prescriptions for payment in the point of service (POS) system. The current version is available online at http://www.Lni.wa.gov/ClaimsIns/Files/Providers/PayerSheet.pdf

INITIAL PRESCRIPTION DRUGS OR "FIRST FILLS"

L&I **will** pay pharmacies or reimburse workers for prescription drugs prescribed during the initial visit for State Fund claims regardless of claim acceptance. Refer to WAC 296-20-01002 for definitions of initial prescription drug and initial visit.

L&I **won't** pay:

- For refills of the initial prescription before the claim is accepted,
- For new prescription written after the initial visit but before the claim is accepted or
- If it is a federal or self-insured claim. Pharmacies should bill the appropriate federal or self-insured employer.

If a payment is made by L&I on a claim that has been mistakenly filed as a State Fund claim, payment will be recovered.

Payment for "first fills" shall be based on L&I's fee schedule including but not limited to screening for drug utilization review (DUR) criteria, preferred drug list (PDL) provisions, 30-day supply limit and formulary status. Your bill must be received by L&I within 1 year of the date of service. For additional information and billing instructions, go to http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Billing/default.asp#3 or see the Pharmacy Prescription Billing Instructions manual.

THIRD PARTY BILLING FOR PHARMACY SERVICES

Pharmacy services billed through a third party pharmacy biller **will be paid** using the pharmacy fee schedule **only when**:

- A valid L&I claim exists; and
- The dispensing pharmacy has a signed Third Party Pharmacy Supplemental Provider Agreement on file at L&I; and
- All POS edits have been resolved during the dispensing episode by the dispensing pharmacy.

L&I pharmacy providers that bill through a third party pharmacy billing service must:

- Sign a Third Party Pharmacy Supplemental Provider Agreement
- Allow third party pharmacy billers to route bills on their behalf,
- Agree to follow L&I rules, regulations and policies and
- Ensure that third party pharmacy billers use L&I's online POS system and
- Review and resolve all online POS system edits using a **licensed pharmacist** during the dispensing episode.

Third party pharmacy billers **can't resolve** POS edits. Third Party Pharmacy Supplemental Agreements can be obtained either through the third party pharmacy biller or by contacting Provider Accounts at (360) 902-5140. The third party pharmacy biller and the pharmacy complete the agreement together and return it to L&I. For more information refer to the Pharmacy Services website at http://www.Lni.wa.gov/ClaimsIns/Providers/Treatment/Presc/default.asp.

EMERGENCY CONTRACEPTIVES AND PHARMACIST COUNSELING

The insurer covers emergency contraceptive pills (ECPs) and associated pharmacist counseling services when **all** of the following conditions are met:

- A valid claim for rape in the workplace is established with the insurer, and
- The ECP and/or counseling service is sought by the worker, and
- The claim manager authorizes payment for the ECP and/or the counseling, and
- The pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

Once these conditions have been met, the dispensed medication must be billed with the appropriate NDC and the counseling service with HCPCS code S9445.

INFUSION THERAPY

Services

These services require **prior authorization** by the insurer. The insurer will only pay home health agencies and/or independent registered nurses for infusion therapy services and/or therapeutic, diagnostic, vascular injections.

Supplies

Only pharmacies and DME suppliers, including IV infusion companies, may be paid for infusion therapy supplies. **Prior authorization is required** for supplies (including infusion pumps) and must be billed with HCPCS codes. See WAC 296-20-1102 for information on the rental or purchase of infusion pumps. Implantable infusion pumps are **not routinely covered**.

> **Exception:** When a spinal cord injury is the accepted condition the insurer may pay for an implantable pump for Baclofen. See WAC 296-20-03014(6).

Drugs

Infusion therapy drugs, including injectable drugs, are **payable only to pharmacies**. Drugs must be authorized and billed with NDC codes or UPC codes if NDC codes are not available.

DURABLE MEDICAL EQUIPMENT (DME)

Pharmacies and DME providers must bill their "usual and customary" charge for supplies and equipment with appropriate HCPCS and local codes. Delivery charges, shipping and handling, tax, and fitting fees **aren't payable separately**. Include these charges in the total charge for the supply. See WAC 296-20-1102 for information on the rental or purchase of DME.

PURCHASING OR RENTING DME

Required Modifiers –NU or –RR

A modifier is always required on all HCPCS codes that are used to purchase or rent DME.

–NU for a new purchase or

–RR for a rental.

The HCPCS Section of the Professional Services Fee Schedule lists the HCPCS E codes and the HCPCS K codes that require either –NU or –RR. Look in the HCPCS/CPT® code column of the fee schedule for the appropriate modifier. There is also a column in fee schedule that designates the HCPCS code as requiring prior authorization. There is no need to obtain prior authorization if the code doesn't require it.

DME codes fall into one of 3 groups relative to modifier usage. DME that is:

- Only purchased (only –NU modifier allowed).
- Only rented (only –RR modifier allowed).
- Either purchased or rented (either –NU or –RR modifier allowed).

Bills submitted without the correct modifier will be denied payment. Providers may continue to use other modifiers, for example –LT,–RT, etc., in conjunction with the mandatory modifiers if appropriate (up to 4 modifiers may be used on any 1 HCPCS code).

Exceptions:

- K0739: Repair or non-routine service for durable medical equipment other then oxygen equipment requiring the skill of a technician, labor component, per 15 minutes doesn't require a modifier.
- K0740: Repair or no routine service for oxygen equipment requiring the skill of a technician, labor component, per 15 minutes.

L&I **won't** purchase used equipment.

Self-insured employers **may purchase** used equipment.

DME Purchase

Purchased DME must have the –NU modifier. The new purchase codes and their modifier can be found in the HCPCS Section of the Professional Services Fee Schedule. Purchased DME belongs to the worker.

DME Rental

DME that is rented must have the –RR modifier. The rental codes and their modifier can be found in the HCPCS Section of the Professional Services Fee Schedule.

Rental payments will not exceed 12 months. At the 12th month of rental, the equipment is **owned by the worker**. The insurer may review rental payments at 6 months and decide to purchase the equipment at that time. The purchased DME belongs to the worker.

The maximum allowable rental fee is based on a per month period. Rental of 1 month or less is equal to 1 unit of service.

Exceptions:

- E0935 and E0936, continuous passive motion exercise device for use on knee only and continuous passive motion exercise device for use other than knee respectively are rented on a per diem basis up to 14 days with 1 unit of service equaling 1 day.
- E1800-E1818, E1825-E1840, extension/flexion device. These devices are rented for 1 month. If needed beyond 1 month, a claims manager's authorization is required.

If the equipment is being rented for 1 day, use the same date for the first and last dates of service. If the equipment is being rented for more than 1 day, use the actual first and last dates of service. Errors will result in suspension and/or denial of payment of the bill and any subsequent bills. Some equipment will only be rented by the insurer.

During the authorized rental period, the DME belongs to the provider. When the equipment is no longer authorized, the DME will be returned to the provider. If the unauthorized DME isn't returned to the provider within 30 days, the provider can bill the worker for charges related to DME rental, purchase and supplies that accrue after DME authorization is denied by the insurer.

DME Purchase after Rental

Equipment rented for less than 12 months and permanently required by the worker:

- The provider will retrieve the rental equipment and replace it with the new DME item.
- The provider should bill the usual and customary charge for the new replacement DME item. The HCPCS code billed will require a –NU modifier.
- L&I will pay the provider the new purchase price for the replacement DME item in accordance with the established maximum fee.
- Self-insurers may purchase the equipment and receive rental credit toward the purchase.

DME, Miscellaneous, E1399

HCPCS code E1399 will be paid by report.

- E1399 is payable only for DME that doesn't have a valid HCPCS code assigned.
- All bills for E1399 items must have either the –NU or –RR modifier.
- A description must be on the paper bill or in the remarks section of the electronic bill.
- The item must be appropriate relative to the injury or type of treatment being received by the worker.

OXYGEN AND OXYGEN EQUIPMENT

L&I primarily rents oxygen equipment and will no longer rent to purchase.

Types of Oxygen Systems

Stationary systems: Stationary oxygen systems include gaseous oxygen cylinders, liquid oxygen systems and oxygen concentrators.

- Oxygen gas cylinders contain oxygen gas stored under pressure in tanks or cylinders. Large H cylinders weigh approximately 200 pounds and provide continuous oxygen at 2 liters per minute for 2.5 days.
- Liquid oxygen systems store oxygen in a reservoir as a very cold liquid that converts to gas when released from the tank. Liquid oxygen is more expensive than compressed gas but takes up less space and can be more easily transferred to a portable tank. A typical liquid oxygen system weighs approximately 120 pounds and provides continuous oxygen at 2 liters per minute for 8.9 days. Certain liquid oxygen systems can provide oxygen at the same rate for 30 days or more.
- Oxygen concentrators are electric devices that extract oxygen from ambient air and deliver oxygen at 85% or greater at concentration of up to 4 liters per minute. A back-up oxygen cylinder is used in the event of a power failure for patients on continuous oxygen using concentrators.

Portable systems: Portable oxygen systems may be appropriate for patients with stationary oxygen systems who are ambulatory within the home and occasionally go beyond the limits of the stationary system tubing. Some portable oxygen systems, while lighter in weight than stationary systems, aren't designed for patients to carry.

- Small gas cylinders, such as the E cylinder, are available as portable systems. The E cylinder weighs 12.5 pounds alone, 22 pounds with a rolling cart.
- Portable systems sometimes referred to as ambulatory systems are lightweight (less than 10 pounds) and can be carried by most patients. Small gas cylinders are available that weigh 4.5 pounds.
- Portable liquid oxygen systems that can be filled from the liquid oxygen reservoir are available in various weights. The smallest weighs 3.4 pounds with a conserver and provides oxygen at 2 liters per minute for 10 hours.

Oxygen System Fees

Stationary: Fee schedule payments for stationary oxygen system rentals are all-inclusive. One monthly fee is paid for a stationary oxygen system. This fee includes payment for the equipment, contents (if applicable), necessary maintenance and accessories furnished during a rental month.

If the worker owns a stationary oxygen system, payment will be made for contents of the stationary gaseous (E0441) or liquid (E0442) system.

Portable: Fee schedule payments for portable oxygen system rentals are all-inclusive. One monthly fee is paid for a portable oxygen system. This fee includes payment for the equipment, contents, necessary maintenance and accessories furnished during a rental month.

If the worker owns a portable oxygen system, payment may be made for the portable contents of the gaseous (E0443) or liquid (E0444) portable system.

The fee for oxygen contents (stationary or portable) is billed once a month, not daily or weekly. One unit of service is equal to 1 month of rental.

Oxygen Concentrators

Fee schedule payments for oxygen concentrators are all-inclusive. One monthly fee is paid for an oxygen concentrator. This fee includes payment for the equipment rental, necessary

maintenance and accessories furnished during a rental month.

Oxygen Accessories

Accessories include but aren't limited to:

- Cannulas (A4615)
- Humidifiers (E0555)
- Masks (A4620, A7525)
- Mouthpieces (A4617)
- Nebulizer for humidification (E0580)
- Regulators (E1353)
- Stand/rack (E1355)
- Transtracheal catheters (A4608)
- Tubing (A4616)

These are included in the payment for rented systems. The supplier must provide any accessory ordered by the physician. Accessories are separately payable only when they are used with a patient owned system.

REPAIRS AND NONROUTINE SERVICE

Rented Equipment Repair

Repair, nonroutine service and maintenance are included as part of the monthly rental fee on DME. No additional payment will be provided. This excludes disposable and nonreusable supplies.

Purchased Equipment Repair

Repair, nonroutine service and maintenance on purchased equipment that is out of warranty will be paid by report.

In those cases where damage to a piece of DME is due to worker:

- Abuse,
- Neglect or
- Misuse

The repair or replacement is the responsibility of the worker. Replacement of lost or stolen DME is also the responsibility of the worker.

K0739, K0740 should be billed per each 15 minutes. Each 15 minutes should be represented by one unit of service in the 'Units' field.

> **For example**, 45 minutes for a repair or nonroutine service of equipment requiring a skilled technician would be billed with 3 units of service.

PROSTHETIC AND ORTHOTIC SERVICES

The insurer will only pay for custom fabricated prosthetic and orthotic devices that are manufactured by providers specifically licensed to produce them. These providers include licensed prosthetists, orthotists, occupational therapists, certified hand specialists and podiatrists.

Refer to the "license required" field in the fee schedule to determine if an orthotic or prosthetic device is in this category.

WARRANTIES

A copy of the original warranty is required on each repair service completed. For State Fund claims, send a copy to:

Department of Labor and Industries

PO Box 44291

Olympia, WA 98504-4291

For self-insured claims, send a copy to the SIE/TPA.

http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

Write the claim number in the upper right-hand corner of the warranty document.

Payment will be denied if no warranty is received or if the item is still under warranty.

DME Item Type	Required Warranty Coverage
DME purchased new, excluding disposable and nonreusable supplies	Limited to the manufacturer's warranty
Rented DME	Complete repair and maintenance coverage is provided as part of the monthly rental fee
E1230 Power operated vehicle (3- or 4-wheel nonhighway) "Scooter"	Minimum of 1 year or manufacturer's warranty whichever is greater
Wheelchair frames (purchased new) and wheelchair parts	Minimum of 1 year of manufacturer's warranty whichever is greater
HCPCS codes K0004, K0005 and E1161	Lifetime warranty on side frames and cross braces

For further information on miscellaneous services and appliances, see WAC 296-23-165

BUNDLED CODES

Covered HCPCS codes listed as **bundled** in the fee schedules are payable to pharmacy and DME providers because there is no office visit or procedure associated with these provider types into which supplies can be bundled.

HOT AND COLD PACKS OR DEVICES

Application of hot or cold packs (CPT® code 97010) is bundled for all providers.

Hot or cold therapy durable medical equipment (DME) **isn't covered**.

Exception: HCPCS code A9273, ice caps or collars are **covered** for DME providers only. Hot water bottles, heat and / or cold wraps aren't covered.

WAC 296-20-1102 prohibits payment for heat devices for home use including heating pads. These devices are either bundled or **not covered**.

AUTHORIZATION REQUIREMENTS

Providers aren't required to obtain prior authorization for orthotics or DME when:

- The provider verifies that the claim is open/allowed on the date of service, and
- The orthotic/DME is prescribed by the attending provider (or the surgeon) for an accepted condition on the correct side of the body, and
- The fee schedule prior authorization indicator field is blank.

Prior authorization **is required** for:

- Prosthetics, surgical appliances and other special equipment described in WAC 296-20-03001, Treatment requiring authorization.
- Replacement of specific items on closed claims per WAC 296-20-124, Rejected and closed claims.

If DME or orthotics requires **prior authorization** and it isn't obtained, then bills may be denied.

For more information, contact the Provider Hotline at 1-800-848-0811 or 360-902-6500 (from Olympia).

Contact the self-insured employer or their third party administrator for prior authorization on self-insured claims. http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

DENTAL SERVICES

Dental providers licensed in the state in which they practice may be paid for performing dental services (WAC 296-20-110 and WAC 296-23-160).

This policy pertains to bills submitted for dental services.

PRE-EXISTING CONDITIONS

Pre-existing conditions aren't payable unless medically justified as related to the injury. Preauthorization is required for treatment.

Any dental work needed due to underlying conditions unrelated to the industrial injury is the responsibility of the worker (WAC 296-20-110). It is the responsibility of the dentist to advise the worker accordingly. Please advise the worker if there are underlying conditions that will not be covered.

Periodontal disease is an underlying condition that isn't covered because it isn't related to industrial injuries.

To avoid delays in treatment, please exclude information regarding treatment that isn't directly related to the injury.

WHO CAN BILL

Dental providers including:

- Dentists
- Oral and Maxillofacial surgeons
- Orthodontists
- Denturists
- Hospitals
- Dental clinics

BILLING RULES

Provider Number

You must have an L&I provider account number to treat and be paid for services provided to injured workers (WAC 296-20-015). You can find more information about becoming an L&I provider at http://www.lni.wa.gov/ClaimsIns/Providers/Becoming/default.asp

For self-insured workers' compensation claims contact the insurer directly for provider account number requirements. For assistance in locating self-insurers go to:

http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

BILLING INSTRUCTIONS

Billing Forms

To bill for workers' compensation claims, dentists should use L&I's Statement for Miscellaneous Services form. To bill for Crime Victims Compensation (CVC) claims, dentists should use CVC's Statement for Crime Victims Miscellaneous Services. Forms can be found at http://www.Lni.wa.gov/FormPub/BySubject.asp.

Failure to use L&I's most recent billing form may delay payment.

Complete the billing form itemizing the service rendered, including the code, materials used and the injured tooth number(s). When using Current Dental Terminology (CDT®) codes, please include the "**D**" in front of the code billed to avoid delays in claim/bill processing.

Bills must be submitted within one year from the date the service is rendered (WAC 296-20-125).

AUTHORIZATION AND TREATMENT PLAN REQUIREMENTS

Contact the following for procedures requiring prior authorization:

- L&I claim manager for state workers' compensation claims and CVC claims
- Self-insured employer or their third party administrator

Only claim managers can authorize dental services for State Fund workers' compensation claims and CVC claims.

For self-insured workers' compensation claims, contact the insurer directly for prior authorization procedure details.

http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

To obtain authorization for a treatment plan the following are required:

- Causal relationship of injury to condition of the mouth and teeth.
- Extent of injury.
- Alternate treatment plan.
- Time frame for completion.
- Medical history and risk level for success.

Please include:

- Procedure code.
- Tooth number.
- Tooth surface.
- Charge amount.

Don't use a billing form to submit your treatment plan.

TREATMENT PLAN SUBMISSION

Claim services requiring prior authorization require a treatment plan. The dentist should outline the extent of the dental injury and the treatment plan (WAC 296-20-110).

The treatment plan and/or alternative treatment plan must be completed and submitted before authorization can be granted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

PRIOR AUTHORIZATION REVIEW

The claim manager will review the treatment plan and the relation to the industrial injury and make a final determination for all services relating to restorative, endodontic, prosthodontic, prosthetic, implant, orthodontics, surgery and anesthesia procedures.

In cases presenting complication, controversy or diagnostic/therapeutic problems, consultation by another dentist may be requested by the claim manager to support authorization for procedures.

To avoid delays in authorization of treatment, include the following in your plan:

- Worker's full name,
- Claim number,
- Provider name, address and telephone number

State the condition of the mouth and involved teeth including:

- Missing teeth, existing caries and restorations.
- Condition of involved teeth prior to the injury (caries, periodontal status).

Mail State Fund **treatment plans** to:
Department of Labor & Industries
PO Box 44291
Olympia, Washington 98504-4291

State Fund treatment plans (**not billing** info) may be faxed to:
(360) 902-4567

Mail CVC claim **treatment plans** to:
Department of Labor & Industries
PO Box 44520
Olympia, Washington 98504-4520

Mail self-insured treatment plans to the SIE/TPA.
http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

DOCUMENTATION AND RECORDKEEPING REQUIREMENTS

Chart Notes

You must submit legible chart notes and reports for all of your services. This documentation must verify the level, type and extent of service (WAC 296-20-010). Legible copies of office notes are required for all initial and follow-up visits (WAC 296-20-06101).

Acceptance of a Claim

If you diagnose a worker for an occupational injury or disease associated with a dental condition, you are responsible for reporting this to the insurer. You initiate the State Fund claim or CVC claim for your patient when you send an accident report to L&I.

The State Fund Report of Industrial Injury or Occupational Disease (Accident Report) (ROA) form can be ordered at:

http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1599 or call 1-800-LISTENS or 1-360-902-4300.

To request a supply of the Provider's Initial Report (PIR) form used for workers of self-insured employers, go to http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2467, or call 1-360-902-6898.

Attending Provider

If dental treatment is the only treatment the injured worker requires and you are directing the care, you will be the attending provider (AP).

Your responsibility as the AP includes:

- Documenting employment issues in the injured worker's chart notes, including:
  - A record of the worker's physical and medical ability to work, and
- Information regarding any rehabilitation that the worker may need to undergo.
- Restrictions to recovery,
- Any temporary or permanent physical limitations, and
- Any unrelated condition(s) that may delay recovery must also be documented.

For ongoing treatment, use the standard **SOAP** (Subjective, Objective, Assessment, Plan and progress) format. Information on the format can be found in the Charting Format section, page **19** of this document.

L&I'S REVIEW OF DENTAL SERVICES

L&I or its designee may perform periodic independent evaluations of dental services provided to workers. Evaluations may include, but aren't limited to, review of the injured worker's dental records.

HOME HEALTH SERVICES

Home Health Services include attendant care, home health, home care, infusion therapy, and hospice. All of these services require **prior authorization**. The insurer will only pay for proper and necessary services required to address physical restrictions caused by the industrial injury or disease.

ATTENDANT CARE SERVICES

Attendant care services provide assistance in the home for personal care and activities of daily living. Attendant care services must be provided by an agency that is licensed, certified or registered to provide home health or home care services. Attendant care agencies must have registered nurse (RN) supervision of care givers providing care to a worker. In addition to prior authorization, attendant care agencies must obtain a provider account number and bill with the appropriate code(s) to be reimbursed for services. RN supervision services aren't paid separately and are included in the hourly fee as business overhead. Attendants for workers may be:

- Registered aides
- Certified nurse's aides
- Licensed practical nurses
- RNs

The agency providing services must be able to provide the type of attendant care and supervision necessary to address the worker's medical and safety needs. Agency services can be terminated if the agency can't provide the necessary care.

The agency can't bill for more than 12 hours per day for any one caregiver. The agency can't bill for care during the time the caregiver is sleeping.

All RN evaluation reports must be submitted to the insurer within 15 days of the initial evaluation and then annually or when the worker's condition changes and necessitates a new evaluation. Documentation to support daily billing must be submitted to the insurer and include:

- Begin and end time of each caregiver's shift
- Name, initials, and title of each caregiver
- Specific care provided and who provided the care.

The insurer will notify the provider in writing if current approved hours are modified or changed. Refer to WAC 296-20-091 and WAC 296-23-246 for additional information.

The insurer will determine the maximum hours and type of authorized attendant care required based on the nursing assessment of the worker's personal care needs. Personal care may include but isn't limited to:

- Administration of medication
- Bathing
- Personal hygiene and skin care
- Bowel and bladder incontinence
- Feeding assistance
- Mobility assistance
- Turning and positioning,
- Transfers or walking
- Supervision due to cognitive impairment, behavior or blindness.
- Range of motion exercises
- Ostomy care

Attendant care services may be terminated or not authorized if:

- Behavior of worker or others at the place of residence is threatening or abusive,
- Worker is engaged in criminal or illegal activities,
- Worker doesn't have the cognitive ability to supervise attendant and there isn't an adult family member or guardian available to supervise the attendant,
- Residence is unsafe or unsanitary and places the attendant or worker at risk,
- Worker is left unattended during approved service hours by the approved provider.

Attendant Service Codes

Code	Description	Fee
S9122	Attendant in the home provided by a home health aide or certified nurse assistant per hour	$26.01
S9123	Attendant in the home provided by a registered nurse per hour	$56.57
S9124	Attendant in the home provided by licensed practical nurse per hour	$41.29

Bundled Codes and DME

Attendant care agencies may bill for wound care and medical treatment supplies. Covered HCPCS codes which are listed as bundled in the fee schedule are separately payable to home attendant care service providers for supplies used in the worker's home.

When caregivers are providing wound care, prior authorization and a prescription from the treating provider is required to bill for infection control supplies (HCPCS code S8301). An invoice for the supplies must be submitted with the bill.

Noncovered Services

Social work services **aren't covered**, except as part of home hospice care.

Chore services and other services that are only needed to meet the worker's environmental needs **aren't covered**. The following services are examples of chore services.

- Childcare
- Laundry and other housekeeping activities
- Meal planning and preparation
- Other everyday environmental needs unrelated to the medical care of the worker
- Recreational activities
- Shopping and running errands for the worker
- Transportation of the worker
- Yard work
- Work associated activities

Workers must not be left unattended during approved service hours. Attendant care providers may not bill for services the attendant performs in the home while the worker is away from the home.

Attendant care services won't be covered when a worker is in the hospital or a nursing facility unless the worker's industrial injury causes a special need that the hospital or nursing facility can't provide and attendant care is specifically authorized to be provided in the hospital or nursing facility.

The agency can bill workers for hours not approved by the insurer if worker is notified in advance that they are responsible for payment.

Spouse Attendant Care

Spouses who aren't employed by an agency, who provided insurer approved attendant services to the worker prior to October 1, 2001, and who met criteria in the year 2002, may continue to bill for spouse attendant care (per WAC 296-23-246).

Spouse attendants may bill up to 70 hours per week. Spouse attendants won't be paid during sleeping time. Exemptions to this limit will be made based on insurer review. The insurer will determine the maximum hours of approved attendant care based on an independent nurse evaluation which must be performed yearly. If the worker requires more than 70 hours per week of attendant care, the insurer can approve a qualified agency to provide the additional hours of care. The insurer will determine the maximum amount of additional care based on an RN evaluation.

Spouse Attendant Code

Code	Description	Fee
8901H	Spouse attendant in the home per hour	$12.78

Travel Not Related To Medical Care

A worker who qualifies for attendant care and is planning a long distance trip must inform the insurer of the plans and request specific authorization for coverage during the trip. The insurer **won't cover** travel expenses of the attendant or authorize additional care hours. The worker must coordinate the trip with the appropriate attendant care agencies. Mileage, parking, and other travel expenses of the attendant when transporting a worker are the responsibility of the worker.

Respite Attendant Care

The insurer can approve short term agency attendant care services for a spouse or family member who provides either paid or unpaid attendant care when respite (relief) care is required. Respite care must be pre-authorized by the insurer.

A nursing evaluation (see Nursing Evaluations) will be conducted to determine the level or care and the maximum hours of service required if a current nursing assessment isn't available. The insurer will notify the agency in writing when services are approved. The agency providing respite care must meet L&I criteria as a provider of home health services.

If in-home attendant care can't be arranged with an agency, a temporary stay in a residential care facility can be approved by the insurer.

The insurer will notify the provider in writing if current approved hours are modified or changed. Spouses won't be paid for respite care.

Nursing Evaluations

An independent nurse evaluation requested by the insurer may be billed under Nurse Case Manager or Home Health Agency RN codes, using their respective codes.

HOSPICE SERVICES

In-home hospice services must be preauthorized and may include chore services. The following code applies to in-home hospice care:

Code	Description	Fee
Q5001	Hospice care, in the home, per diem	By report

For hospice services performed in a facility, please refer to Nursing Home, Residential and Hospice Care Services in the Facility Section.

HOME HEALTH SERVICES

The insurer will pay for aide, RN, physical therapy (PT), occupational therapy (OT), and speech therapy services provided by a licensed home health agency when services become proper and necessary to treat a worker's accepted condition. Home health services require prior authorization. Home health services are for intermittent or short term treatment or therapy for a medical condition. Home health services must be requested by a physician.

Services require an initial evaluation by the RN or PT/OT and a written report must be submitted to the insurer within 15 days of the evaluation.

Payment for continued treatment will require documentation of the worker's needs and progress and renewed authorization at the end of an approved treatment period. The worker is expected to be present and ready for the home health nurse or therapist treatment. Non-cooperation can result in termination of services.

Home health services may be terminated or denied when the worker's medical condition and situation allows for outpatient treatment.

Documentation

Home health care providers must submit the initial assessment, attending provider's treatment plan and/or orders and home care treatment plan within 15 days of beginning the service. Providers must submit documentation to the insurer to support daily billing that includes:

- Begin and end time of each caregiver's shift
- Name, initials, and title of each caregiver
- Specific care provided and who provided the care

Updated plans must be submitted every 30 days thereafter.

Home Health Codes

Code	Description	Fee
G0151	Services of Physical Therapist in the home. 15 min. units. Maximum of 4 units per day.	$37.32
G0152	Services of Occupational Therapist in the home. 15 min units. Maximum of 4 units per day.	$38.69
G0153	Services of Speech and Language Pathologist in the home. 15 min units. Maximum of 4 units per day.	$38.69
G0154	Services of skilled nurse RN/LPN in the home. 15 min units.	$38.69
G0156	Services of home health aide in the home. 15 min units. Maximum of 96 units per day.	$6.50
G0162	Services of skilled nurse (RN) evaluation and management of the plan of care, 15 min units.	$38.69

Bundled Codes and DME

Home health and home infusion services may bill appropriate HCPCS codes for wound care and medical treatment supplies. Covered HCPCS codes listed as bundled in the fee schedule are separately payable to home health and home care providers for supplies used during the home health visit. See WAC 296-20-01002 for the definition of bundled services. Durable medical equipment may require specific authorization prior to purchase.

HOME INFUSION SERVICES

Home infusion services provide drug administration, parenteral hydration, and parenteral feeding to a worker in the home. Skilled nurses contracted by the home infusion service provide education of the worker and family, evaluation and management of the infusion therapy, and care for the infusion site.

Home infusion skilled nurse services will only be authorized when infusion therapy is approved as treatment for the worker's allowed industrial condition. Prior authorization is required for home infusion nurse services, drugs, and any supplies, regardless of who is providing services. Home infusion services can be authorized independently or in conjunction with home health services.

Infusion therapy drugs, including injectable drugs, are payable only to pharmacies. Drugs must be authorized and billed with National Drug Code (NDC) codes or Universal Product Code (UPC) codes if no NDC codes are available.

The rental or purchase of infusion pumps must be billed with the appropriate HCPCS codes.

See WAC 296-20-1102 for additional information.

> **NOTE:** Home health agencies must have prior authorization and use the RN G0154 visit code when administering home injections or nutritional parenteral solutions only.

Medical Supply companies and home infusion pharmacies may use the appropriate HCPCS code to bill for parenteral solutions, total parental nutrition (TPN), or enteral formula nutrition with prior authorization. Home infusion codes may be billed for initial establishment of nutritional therapy for the worker when services have been authorized.

Home Infusion Codes

Code	Description	Fee
99601	Skilled RN visit for infusion therapy in the home. First 2 hours per visit.	$149.32
99602	Skilled RN visit for each additional hour per visit.	$62.79

SUPPLIES, MATERIALS AND BUNDLED SERVICES

Services and supplies must be medically necessary and must be prescribed by an approved provider for the direct treatment of an **accepted** condition. Supplies include, but aren't limited to:

- Drugs administered in a provider's office
- Medical and surgical supplies
- Prefabricated orthotics.

Providers must bill specific HCPCS or local codes for supplies and materials provided during an office visit or with other office services. The insurer won't pay CPT® code 99070, which represents miscellaneous supplies and materials provided by the physician.

Under the fee schedules, some services and supply items are considered bundled into the cost of other services (associated office visits or procedures) and won't be paid separately. See WAC 296-20-01002 for the definition of bundled codes.

Supplies used in the course of an office visit are considered bundled and aren't payable separately.

Fitting fees are bundled into the office visit or into the cost of any DME and aren't payable separately.

Billing Tip

NOTE: Bundled codes contain the word bundled in the dollar value column in the Professional Services Fee schedule. Refer to **Appendices B and C** for lists of bundled services and supplies.

ACQUISITION COST POLICY

NOTE: This policy doesn't apply to hospital bills. Refer to the Facilities Section for the hospital acquisition cost policy, page **189**189.

Supply codes without a fee listed **will be paid** at their acquisition cost.

The total acquisition cost should be billed as 1 charge. The acquisition cost equals:

- The wholesale cost plus
- Shipping and handling plus
- Sales tax.

For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill but isn't required.

Wholesale invoices for all supplies and materials must be kept in the provider's office files for a minimum of 5 years.

A provider must submit a hard copy of the wholesale invoice to the insurer when billing for a supply item that costs $150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Billing Tip

Sales tax and shipping and handling charges aren't paid separately, and must be included in the total charge for the supply. An itemized statement showing net price plus tax may be attached to bills but isn't required.

CASTING MATERIALS

Bill for casting materials with HCPCS codes Q4001-Q4051. No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

MISCELLANEOUS SUPPLIES

The following supplies must be billed with HCPCS Code E1399:

- Therapy putty and tubing
- Anti-vibration gloves

Bills coded with E1399 will be reviewed for payment and must meet the following criteria:

- E1399 is payable only for DME that doesn't have a valid HCPCS code assigned.
- All bills for E1399 items must have either the –NU or –RR modifier.
- A description must be on the paper bill or in the remarks section of the electronic bill.
- The item must be appropriate relative to the injury or type of treatment being received by the worker

CATHETERIZATION

Separate payment is allowed for placement of a temporary indwelling catheter when performed in a provider's office and used to treat a temporary obstruction. Payment for the service isn't allowed when the procedure is performed on the same day or during the postoperative period of a major surgical procedure that has a follow up period.

For catheterization to obtain specimen(s) for lab tests, see the Pathology and Laboratory Services section, page **109**.

SURGICAL TRAYS AND SUPPLIES USED IN THE PHYSICIAN'S OFFICE

L&I follows CMS's policy of bundling HCPCS codes for surgical trays and supplies used in a physician's office.

SURGICAL DRESSINGS DISPENSED FOR HOME USE

The cost for surgical dressings applied during a procedure, office visit, or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. No separate payment is allowed.

Primary and secondary surgical dressings dispensed for home use are payable at acquisition cost when **all** of the following conditions are met:

- They are dispensed to a patient for home care of a wound and
- They are medically necessary and
- The wound is due to an accepted, work-related condition.

Primary Surgical Dressings

Primary surgical dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Examples of primary surgical dressings include items such as:

- Telfa
- Adhesive strips for wound closure
- Petroleum gauze

Secondary Surgical Dressings

Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. Examples include items such as: adhesive tape, roll gauze, binders, and disposable compression material. They don't include items such as elastic stockings, support hose and pressure garments. These items must be billed with the appropriate HCPCS.

Providers must bill the appropriate HCPCS code for each dressing item, along with the local modifier –1S for each item. Surgical dressing supplies and codes billed without the local modifier –1S are considered bundled and won't be paid.

HOT AND COLD PACKS OR DEVICES

The application of hot or cold packs is bundled for all providers.

Hot or cold therapy durable medical equipment (DME) **isn't covered**.

Exception: E0230, Ice cap or collar, is **covered** for DME providers only.

WAC 296-20-1102 prohibits payment for heat devices for home use including heating pads. These devices are either bundled or **not covered** (see **Appendices B, C and D and the Durable Medical Equipment section**).

AMBULANCE SERVICES

GENERAL INFORMATION

The ambulance services payment policies are primarily based on the current Medicare payment policies for ambulance services modified to meet the needs of Washington State's workers.

VEHICLE AND CREW REQUIREMENTS

To be eligible to be paid for ambulance services for workers, the provider must meet the criteria for vehicles and crews as established in WAC 246-976 "Emergency Medical Services and Trauma Care Systems" and other requirements as established by the Washington State Department of Health for emergency medical services.

Key sections of this WAC are identified below:

1. General
    - WAC 246-976-260 Licenses required
2. Ground Ambulance Vehicle Requirements
    - WAC 246-976-290 Ground ambulance vehicle standards
    - WAC 246-976-300 Ground ambulance and aid vehicles--Equipment
    - WAC 246-976-310 Ground ambulance and aid vehicles--Communications equipment
    - WAC 246-976-390 Verification of trauma care services
3. Air Ambulance Services
    - WAC 246-976-320 Air ambulance services
4. Personnel
    - WAC 246-976-182 Authorized care
    - Washington State Department of Health, Office of Emergency Medical Services Certification Requirements Guidelines

PAYMENT POLICIES FOR AMBULANCE RELATED SERVICES

Emergency Transport

Ambulance services are paid when the injury to the worker is so serious that use of any other method of transportation is contraindicated. Payment is based on the level of medically necessary services provided, not simply on the vehicle used.

Air ambulance transportation services, either by helicopter or fixed wing aircraft, will be paid only if:

- The worker's medical condition requires immediate and rapid ambulance transportation that couldn't have been provided by ground ambulance or
- The point of pickup is inaccessible by ground vehicle or
- Great distances or other obstacles are involved in getting the worker to the nearest place of proper treatment.

Proper Facilities

The insurer pays the provider for ambulance services to the nearest place of proper treatment. To be a place of proper treatment, the facility must be generally equipped to provide the needed medical care for the worker. A facility isn't considered a place of proper treatment if no bed is available when inpatient medical services are required.

Multiple Patient Transportation

The insurer pays the appropriate base rate for each worker transported by the same ambulance. When multiple workers are transported in the same ambulance, the mileage will be prorated equally among all the workers transported. The provider must use HCPCS Modifier GM (Multiple Patients on 1 Ambulance Trip) for the appropriate mileage billing codes. The provider is responsible for prorating mileage billing codes based on the number of workers transported on the single ambulance trip.

Nonemergency Transport

Nonemergency transportation by ambulance is appropriate if:

- The worker is bed-confined (see bed-confined criteria below), and it is documented that the worker's accepted medical condition is such that other methods of transportation are contraindicated or
- If the worker's accepted medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Bed-confined criteria:

- The worker is unable to get up from bed without assistance, and
- The worker is unable to ambulate, and
- The worker is unable to sit in a chair or wheelchair.

Nonemergency transportation may be provided on a scheduled (repetitive or nonrepetitive) or unscheduled basis.

- Scheduled, nonemergency transportation may be repetitive, for example, services regularly provided for diagnosis or treatment of the worker's accepted medical condition or nonrepetitive, for example, single time need
- Unscheduled services generally pertain to nonemergency transportation for medically necessary services

Workers may not arrange nonemergency ambulance transportation. Only medical providers may arrange for nonemergency ambulance transportation.

The insurer reserves the right to perform a post-audit on any nonemergency ambulance transportation billing to ensure medical necessity requirements are met.

Arrival of Multiple Providers

When multiple providers respond to a call for services, only the provider that furnishes the transport of the worker(s) is eligible to be paid for the services provided. No payment is made to the other provider(s).

Mileage

The insurer pays for mileage (ground and/or air) based on loaded miles only, for example, from the pickup of the worker(s) to their arrival at the destination. The destination is defined as the nearest place of proper treatment.

AMBULANCE SERVICES FEE SCHEDULE

HCPCS Code	Description	Fee Schedule
A0425	Ground mileage, per statute mile	$12.81 per mile
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	$633.83
A0427	Ambulance service, advanced life support, level 1 (ALS 1-emergency)	$657.87
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	$346.24
A0429	Ambulance service, basic life support, emergency transport (BLS – emergency)	$554.00
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	$5,652.91
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	$6,572.32
A0433	Advanced Life Support, Level 2 (ALS 2)	$952.18
A0434	Specialty care transport (SCT)	$1,125.31
A0435	Fixed wing air mileage, per statute mile	$31.47 per mile
A0436	Rotary wing air mileage, per statute mile	$73.11 per mile
A0999	Unlisted ambulance service	By report restrictions: (1) Reviewed to determine if a more appropriate billing code is available; and (2) Reviewed to determine if medically necessary

AUDIOLOGY AND HEARING SERVICES

The following policies and requirements apply to all hearing aid services and devices except for CPT® codes.

SELF-INSURERS

SIEs that have entered into contracts for purchasing hearing aid related services and devices may continue to use them. (See WAC 296-23-165 section 1(b).) SIEs that don't have hearing aid purchasing contracts must follow L&I's maximum fee schedule and purchasing policies for all hearing aid services and devices listed in this section.

AUTHORIZATION REQUIREMENTS

Initial and Subsequent Hearing Related Services

Prior authorization must be obtained from the insurer for all initial and subsequent hearing related services, devices, supplies and accessories in accordance with WAC 296-20-03001 and WAC 296-20-1101. The insurer won't pay for hearing devices provided prior to authorization.

> **NOTE:** In cases of special need, such as when the worker is working and a safety issue exists, the provider may be able to obtain the insurer's authorization to dispense hearing aid(s) after the doctor's examination and before the claim is accepted. The insurer will notify the worker in writing when the claim is accepted or denied.

The authorization process for State Fund claims may be initiated by calling the claim manager or the State Fund's Provider Hotline at 1-800-848-0811 (in Olympia call 902-6500).

For self-insured claims, the provider should obtain **prior authorization** from the SIE or its TPA.

Trial Period

A 30-day trial period is the standard established by RCW 18.35.185. During this time, the provider supplying the aids must allow workers to have their hearing aids adjusted or be returned without cost for the aids and without restrictions beyond the manufacturer's requirements (for example, hearing aids aren't damaged). Follow up hearing aid adjustments are bundled into the dispensing fee. If hearing aids are returned within the 30-day trial period, the provider must refund the hearing aid and dispensing fee.

Types of Hearing Aids Authorized

The insurer will purchase hearing aids of appropriate technology to meet the worker's needs (for example, digital). The decision will be based on recommendations from physicians, ARNPs, licensed audiologists, or fitter/dispensers. Based on current technology, the types of hearing aids purchased for most workers are digital or programmable in the ear (ITE), in the canal (ITC), and behind the ear (BTE).

Any other types of hearing aids needed for medical conditions will be considered based on justifications from the physician, ARNP, licensed audiologist, or fitter/dispenser.

L&I won't purchase used or repaired equipment.

Hearing Aid Quality

All hearing aid devices provided to workers must meet or exceed all Food and Drug Administration (FDA) standards. All manufacturers and assemblers must hold a valid FDA certificate.

Masking Devices for Tinnitus

In cases of accepted tinnitus, the department or self-insurer may authorize masking devices. If masking devices are dispensed without hearing aids, providers will bill using code E1399. When dispensed as a component of a hearing aid, providers will bill using code V5267. Providers must bill masking devices at their acquisition cost. Refer to the Acquisition Cost

Policy on page **135** for more detail. If masking devices are dispensed without hearing aids, the provider may also bill the appropriate dispensing fee code for monaural or binaural devices.

Special Authorization for Hearing Aids and Masking Devices over $900 per Ear

If the manufacturer's invoice cost of any hearing aid or masking device exceeds $900 per ear including shipping and handling, special authorization is required from the claim manager.

> **Exception:** The cost of BTE ear molds doesn't count toward the $900 for special authorization. Initial BTE ear molds may be billed using V5264, and replacements may be billed using V5014 with V5264.

Authorized Testing

Testing to fit a hearing aid may be done by a licensed audiologist, fitter/dispenser, qualified physician, or qualified ARNP. The provider must obtain **prior authorization** for subsequent testing. The insurer doesn't pay for testing after a claim has closed unless related to fitting of replacement hearing aids.

The insurer doesn't cover annual hearing tests.

If free initial hearing screenings are offered to the public, the insurer won't pay for these services.

Required Documentation

The insurer will authorize hearing aids only when prescribed or recommended by a physician or ARNP and the claim for hearing loss has been allowed. State Fund claim managers use the information outlined below to decide whether an individual worker has a valid work-related hearing loss An SIE/TPA may use these or similar forms to gather information.

- Report of Accident
- Occupational Disease Employment History Hearing Loss (F262-013-000; F262-013-111 continuation)
- Occupational Hearing Loss Questionnaire (F262-016-000)
- Valid audiogram
- Medical report
- Hearing Services Worker Information (F245-049-000)
- Authorization to Release Information (F262-005-000)

PAYMENT FOR AUDIOLOGY SERVICES

The insurer **doesn't pay** any provider or worker to fill out the Occupational Disease Employment History Hearing Loss form or Occupational Hearing Loss Questionnaire.

A physician or ARNP may be paid for a narrative assessment of work-relatedness to the hearing loss condition. Refer to the *Attending Doctors Handbook* table on Other Miscellaneous Codes and Descriptions.

The insurer **will pay** for the cost of battery replacement for the life of an authorized hearing aid. No more than 1 box of batteries (40) will be paid within each 90-day period.

> **NOTE:** Sending workers batteries that they have not requested, and for which they don't have an immediate need, is in violation of L&I's rules and payment policies.

The insurer **won't pay** for any repairs including parts and labor within the manufacturer's warranty period.

The insurer won't pay for the reprogramming of hearing aids.

Hearing Aid Parts and Supplies Paid at Acquisition Cost

Parts and supplies **must be billed** and **will be paid** at acquisition cost including volume discounts (manufacturers' wholesale invoice). **Don't bill** your usual and customary fee.

- Supply items for hearing aids include tubing, wax guards, and ear hooks. These can be billed within the warranty period.
- Parts for hearing aids include switches, controls, filters, battery doors, and volume control covers. These can be billed as replacement parts only, but not within the warranty period.
- Shells ("ear molds" in HCPCS codes) and other parts can be billed separately at acquisition cost. The insurer **doesn't cover** disposable shells.

Hearing aid extra parts, options, circuits and switches, (for example, T-coil and noise reduction switches), can only be billed when the manufacturer doesn't include these in the base invoice for the hearing aid.

Batteries

Only 1 box of batteries (40) is authorized within each 90 day period. Providers must document the request for batteries by the worker and must maintain proof that the worker actually received the batteries.

> **NOTE:** Sending workers batteries that they haven't requested and for which they don't have an immediate need is in violation of L&I's rules and payment policies.

Worker Responsible for Devices That Aren't Medically Necessary

The insurer is responsible for paying for hearing related services and hearing aids that are deemed medically necessary. In the event a worker refuses the recommendations given and wants to purchase different hearing aids, the worker then becomes totally responsible for the purchase of the hearing aid, batteries, supplies and any future repairs.

Worker Responsible for Some Repairs, Losses, Damages

Workers are responsible to pay for repairs and batteries for hearing aids not authorized by the insurer.

The worker is also responsible for nonwork related losses or damages to their hearing aids, (for example, the worker's pet eats/chews the hearing aid, etc...). In no case will the insurer cover this type of damage. In these instances, the worker will be required to buy a hearing aid consistent with current L&I guidelines.

After the worker's purchase and submission of the new warranty to the insurer, the insurer will resume paying for batteries and repairs following the hearing aid payment policies.

REPAIRS AND REPLACEMENTS

The provider who arranges for repairs to hearing aid(s) authorized or purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period.

Warranties

Hearing aid industry standards provide a minimum of a 1 year repair warranty on most hearing devices, which includes parts and labor. Where a manufacturer provides a warranty greater than 1 year, the manufacturer's warranty will apply.

The manufacturer's warranty and any additional provider warranty must be submitted in hard copy to the insurer for all hearing devices and hearing aid repairs.

The warranty should include the make, model and serial number of the individual hearing aid.

Some wholesale companies' warranties also include a replacement policy to pay for hearing aids that are lost. If the hearing aid loss is **covered** under the warranty, the provider must honor the warranty and replace the worker's lost hearing aid without charge.

The insurer doesn't purchase or provide additional manufacturers' or extended warranties beyond the initial manufacturer's warranty (or any additional provider warranty).

The insurer **won't pay** for any repairs, including parts and labor, within the manufacturer's warranty period.

- The warranty begins on the date the hearing aid is dispensed to the worker
- For repairs, the warranty begins when the hearing aid is returned to the worker

Repairs

Prior authorization is required for all billed repairs.

The insurer will repair hearing aids and devices when needed due to normal wear and tear.

- At its discretion, the insurer may repair hearing aids and devices under other circumstances
- After the manufacturer's warranty expires, the insurer will pay for the cost of appropriate repairs for the hearing aids they authorized and purchased
- If the aid is damaged in a work-related incident, the worker must file a new claim to repair or replace the damaged aid

Audiologists and fitters/dispensers may be paid for providing authorized in-office repairs. Authorized in-office repairs must be billed using V5014 and V5267.

For prior authorization of in-office repairs or repairs by the manufacturer or an all-make repair company, providers must submit a written estimate of the repair cost to the Provider Hotline or the SIE claim manager.

Replacement

The insurer doesn't provide an automatic replacement period.

Replacement requests must be sent directly to the insurer.

Documentation that a hearing aid isn't repairable may be submitted by licensed audiologists, fitter/dispensers, all-make repair companies or FDA certified manufacturers. Documentation to support a hearing aid as not repairable must be verified by:

- All-make repair companies or
- FDA certified manufacturers/repair facilities

If only 1 of the binaural hearing aids isn't repairable and if, in the professional's opinion both hearing aids need to be replaced, the provider must submit written, logical rationale for the claim manager's consideration.

The insurer will replace hearing aids when they aren't repairable due to normal wear and tear.

- At its discretion, the insurer may replace hearing aids in other circumstances
- Replacement is defined as purchasing a hearing aid for the worker according to L&I's current guidelines
- The insurer may replace the hearing aid exterior (shell) when a worker has ear canal changes or the shell is cracked. The insurer **won't pay** for new hearing aids when only new ear shell(s) are needed.
- The insurer **won't replace** a hearing aid due to hearing loss changes, unless the new degree of hearing loss was due to continued on-the-job exposure. A new claim must be filed with the insurer if further hearing loss is a result of continued work-related exposure or injury, or the aid is lost or damaged in a work-related incident.
- The insurer **won't replace** hearing aids based solely on changes in technology.
- The insurer **won't pay** for new hearing aids for hearing loss resulting from: noise exposure that occurs outside the workplace; nonwork related diseases and conditions, **or** the natural aging process

The worker must sign and be given a copy of the Hearing Services Worker Information (F245-049-000). The provider must submit a copy of the signed form with the replacement request.

The provider must inform the insurer of the type of hearing aid dispensed and the codes they are billing.

Linear Non-programmable Analog Hearing Aid Replacement Policy

Linear non-programmable analog hearing aids may be replaced with non-linear digital or analog hearing when the worker returns a linear analog hearing aid to their dispenser or audiologist because:

- The hearing aid is inoperable, or
- The worker is experiencing an inability to hear, and
- The insurer has given prior authorization to replace the hearing aid.

The associated professional fitting fee (dispensing fee) will also be paid when the replacement of linear analog with non-linear digital or analog hearing aid is authorized.

Providers must use modifier *RP* with the appropriate hearing aid HCPCS code to be paid for the replacement aid. The *RP* modifier is required to help the insurer track utilization of the replacement hearing aids.

Who Can Bill

Audiologists, physicians, ARNPs and fitter/dispensers who have current L&I provider account numbers may bill for hearing aid replacement. You may bill for the acquisition cost of the non-linear aids, and the associated professional fitting fee (dispensing fee).

Authorization Requirements

Prior authorization must be obtained from the insurer **before** replacing linear analog hearing aids. The insurer **won't pay** for replacement hearing aids issued prior to authorization.

For State Fund claims

- Call the claim manager or
- Fax the request to the Provider Hotline at **360-902-6490**.

For Self-Insured claims

Contact the SIE/TPA for prior authorization. For a list of SIEs/TPAs:

http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

Authorization Documentation and Recordkeeping Requirements

Before authorizing replacement, the insurer will require and request the following documentation from the provider:

- A separate statement (signed by both the provider and the injured worker): "This linear analog replacement request is sent in accordance with L&I's linear analog hearing aid replacement policy." (required)
- Completed Hearing Services Worker Information form (required for State Fund claims). Available at: http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=2032
- Serial number(s) of the current linear analog aid(s), if available.
- Make/Model of the current linear analog aid(s), if available.
- Date original hearing aid(s) issued to worker, if available.

DOCUMENTATION AND RECORD KEEPING REQUIREMENTS

Documentation to Support Initial Authorization

The provider must keep **all** of the following information in the worker's medical records and submit a copy of each to the insurer:

- Name and title of referring practitioner, if applicable, and
- Complete hearing loss history, including whether the onset of hearing loss was sudden or gradual, and
- Associated symptoms including, but not limited to, tinnitus, vertigo, drainage, earaches, chronic dizziness, nausea and fever, and
- A record of whether the worker has been treated for recent or frequent ear infections, and
- Results of the ear examination, and
- Results of all hearing and speech tests from initial examination, and
- Review and comment on historical hearing tests, if applicable, and
- All applicable manufacturers' warranties (length and coverage) plus the make, model, and serial number of any hearing aid device(s) supplied to the worker as original or as a replacement, and
- Original or unaltered copies of manufacturers' invoices, and
- Copy of the Hearing Services Worker Information form (F245-049-000) signed by the worker and provider, and
- Invoices and/or records of all repairs.

Documentation to Support Repair

The provider who arranges for repairs to hearing aid(s) authorized and purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period.

Documentation to Support Replacement

The following information must be submitted to the insurer when requesting authorization for hearing aid replacement.

- The name and credential of the person who inspected the hearing aid, and
- Date of the inspection, and
- Observations, for example, a description of the damage, and/or information on why the

device can't be repaired or should be replaced.

Correspondence with the Insurer

The insurer may deny payment of the provider's bill if the following information has not been received.

- Original or unaltered wholesale invoices from the manufacturer are required to show the acquisition cost and must be retained in the provider's office records for a minimum of 5 years. The insurer **won't accept** invoices printed from email or the internet.
- A hard copy of the original or unaltered manufacturer's wholesale invoice must be submitted by the provider when an individual hearing aid, part or supply costs $150.00 or more, or upon the insurer's request
- **NOTE:** Electronic billing providers must submit a hard copy of the original or unaltered manufacturer's wholesale invoice with the make, model and serial number for individual hearing aids within 5 days of bill submission.

To avoid delays in processing, all correspondence to the insurer must indicate the worker's name and claim number in the upper right hand corner of each page of the document.

For State Fund claims, providers are required to send warranty information to:

Department of Labor and Industries

PO Box 44291

Olympia, WA 98504-4291

For self-insured claims, send warranty information to the SIE/TPA. Contact list is available at http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

ADVERTISING LIMITS

L&I can deny a provider's application to provide services or suspend or revoke an existing provider account if the provider participates in false, misleading, or deceptive advertising, or misrepresentations of industrial insurance benefits. See RCW 51.36.130 and WAC 296-20-015 for more information.

False advertising includes mailers and advertisements that:

- Suggest a worker's hearing aids are obsolete and need replacement.
- Don't clearly document a specific hearing aid's failure.
- Make promises of monetary gain without proof of disability or consideration of current law.

BILLING REQUIREMENTS

Billing for Binaural Hearing Aids

When billing the insurer for hearing aids for both ears, providers must indicate on the CMS-1500 or Statement for Miscellaneous Services form (F245-072-000) the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for each side of the body (right/left).
- Bill the appropriate HCPCS code for binaural aids.
- Only 1 unit of service should be billed even though 2 hearing aids (binaural aids) are dispensed.

NOTE: Electronic billers are to use the appropriate field for the diagnosis code and side of body, specific to their electronic billing format.

Billing for a Monaural Hearing Aid

When billing the insurer for 1 hearing aid, providers must indicate on the CMS-1500 or Statement for Miscellaneous Services form (F245-072-000) the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for the side of the body (right/left) affected.
- Bill the appropriate HCPCS code for monaural aid.
- Only 1 unit of service should be billed.

NOTE: Electronic billers are to use the appropriate field for the diagnosis code and side of body, specific to their electronic billing formats.

Billing for Hearing Aids, Devices, Supplies, Parts and Services

All hearing aids, parts, and supplies must be billed using HCPCS codes. Hearing aids and devices are considered to be durable medical equipment and must be billed at their acquisition cost. Refer to the Acquisition Cost Policy , page **135**, for more detail.

The table below indicates which services and devices are **covered** by provider type.

Provider Type	Service/Device
Fitter/Dispenser	HCPCS codes for all hearing related services and devices
Durable Medical Equipment Providers	Supply and battery codes
Physician, ARNP, Licensed Audiologist	HCPCS codes for hearing related services and devices; and CPT® codes for hearing-related testing and office calls

AUTHORIZED FEES

Dispensing Fees

Dispensing fees cover a 30-day trial period during which all aids may be returned. Also included:

- Up to 4 follow up visits (ongoing checks of the aid as the wearer adjusts to it), and
- 1 hearing aid cleaning kit, and
- Routine cleaning during the first year, and
- All handling and delivery fees.

Restocking Fees

The Washington State Department of Health statute (RCW 18.35.185) and rule (WAC 246-828-290) allow hearing instrument fitter/dispensers and licensed audiologists to retain $150.00 or 15% of the total purchase price, whichever is less, for any hearing aid returned within the rescission period (30 calendar days). This fee is sometimes called a restocking fee. Insurers without hearing aid purchasing contracts will pay this fee when a worker rescinds the purchase agreement.

The insurer must receive Termination of Agreement (Rescission) form (F245-050-000) or a statement signed and dated by the provider and the worker. The form must be faxed to L&I at (360) 902-6252 or forwarded to the SIE/TPA within 2 business days of receipt of the signatures. The provider must submit a refund of the full amount paid by the insurer for the dispensing fees and acquisition cost of the hearing aid that was provided to the worker. The provider may then submit a bill to the insurer for the restocking fee of $150.00 or 15% of the total purchase price, whichever is less. Use code 5091V. Restocking fees can't be paid until the insurer has received the refund.

Fee Schedule

The insurer will only purchase the hearing aids, devices, supplies, parts, and services described in the fee schedule.

HCPCS Code	Description	Maximum Fee
V5008	Hearing screening	$ 76.55
V5010	Assessment for hearing aid	Bundled
V5011	Fitting/orientation/checking of hearing aid	Bundled
V5014	Hearing aid repair/modifying visit per ear (bill repair with code 5093V)	$ 51.04
V5020	Conformity evaluation (1 visit allowed after the 30-day trial period)	Bundled
V5030	Hearing aid, monaural, body worn, air conduction	Acquisition cost
V5040	Body-worn hearing aid, bone	Acquisition cost
V5050	Hearing aid, monaural, in the ear	Acquisition cost
V5060	Hearing aid, monaural, behind the ear	Acquisition cost
V5070	Glasses air conduction	Acquisition cost
V5080	Glasses bone conduction	Acquisition cost
V5090	Dispensing fee, unspecified hearing aid	Not covered
V5100	Hearing aid, bilateral, body worn	Acquisition cost
V5110	Dispensing fee, bilateral	Not covered
V5120	Binaural, body	Acquisition cost
V5130	Binaural, in the ear	Acquisition cost
V5140	Binaural, behind the ear	Acquisition cost
V5150	Binaural, glasses	Acquisition cost
V5160	Dispensing fee, binaural (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	$ 1449.38
V5170	Hearing aid, cros, in the ear	Acquisition cost
V5180	Hearing aid, cros, behind the ear	Acquisition cost
V5190	Hearing aid, cros, glasses	Acquisition cost
V5200	Dispensing fee, cros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	$ 868.72
V5210	Hearing aid, bicros, in the ear	Acquisition cost
V5220	Hearing aid, bicros, behind the ear	Acquisition cost
V5230	Hearing aid, bicros, glasses	Acquisition cost
V5240	Dispensing fee, bicros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	$ 868.72
V5241	Dispensing fee, monaural hearing aid, any type (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	$ 724.69
V5242	Hearing aid, analog, monaural, cic (completely in the ear canal)	Acquisition cost
V5243	Hearing aid, monaural, itc (in the canal)	Acquisition cost
V5244	Hearing aid, digitally programmable analog, monaural, cic	Acquisition cost
V5245	Hearing aid, digitally programmable, analog, monaural, itc	Acquisition cost
V5246	Hearing aid, digitally programmable analog, monaural, ite (in the ear)	Acquisition cost
V5247	Hearing aid, digitally programmable analog, monaural, bte (behind the ear)	Acquisition cost
V5248	Hearing aid, analog, binaural, cic	Acquisition cost
V5249	Hearing aid, analog, binaural, itc	Acquisition cost
V5250	Hearing aid, digitally programmable analog, binaural, cic	Acquisition cost
V5251	Hearing aid, digitally programmable analog, binaural, itc	Acquisition cost
V5252	Hearing aid, digitally programmable, binaural, ite	Acquisition cost
V5253	Hearing aid, digitally programmable, binaural, bte	Acquisition cost
V5254	Hearing aid, digital, monaural, cic	Acquisition cost
V5255	Hearing aid, digital, monaural, itc	Acquisition cost
V5256	Hearing aid, digital, monaural, ite	Acquisition cost

HCPCS Code	Description	Maximum Fee
V5257	Hearing aid, digital, monaural, bte	Acquisition cost
V5258	Hearing aid, digital, binaural, cic	Acquisition cost
V5259	Hearing aid, digital, binaural, itc	Acquisition cost
V5260	Hearing aid, digital, binaural, ite	Acquisition cost
V5261	Hearing aid, digital, binaural, bte	Acquisition cost
V5262	Hearing aid, disposable, any type, monaural	Not covered
V5263	Hearing aid, disposable, any type, binaural	Not covered
V5264	Ear mold (shell)/insert, not disposable, any type	Acquisition cost
V5265	Ear mold (shell)/insert, disposable, any type	Not covered
V5266	Battery for hearing device	$ 0.88
V5267	Hearing aid supply/accessory	Acquisition cost
5091V	Hearing aid restocking fee (the lesser of 15% of the hearing aid total purchase price or $150 per hearing aid)	By report
5092V	Hearing aid cleaning visit per ear (1 every 90 day, after the first year)	$ 23.81
5093V	Hearing aid repair fee. Manufacturer's invoice required	By report

INTERPRETIVE SERVICES

INFORMATION FOR HEALTH CARE AND VOCATIONAL PROVIDERS

Workers or crime victims who have limited English proficiency or sensory impairments may need interpretive services to effectively communicate with providers. Interpretive services don't require **prior authorization**.

Under the Civil Rights Act of 1964, the health care or vocational provider will determine whether effective communication is occurring.

If assistance is needed, the health care or vocational provider:

- Selects an interpreter to facilitate communication.
- Determines if an interpreter (whether paid or unpaid) accompanying the worker meets the communication needs.

If health care or vocational provider determines a different interpreter is needed:

- The worker may be consulted in the selection process.
- Sensitivity to the worker's cultural background and gender is encouraged when selecting an interpreter.
- Ultimate decision rests with health care or vocational provider

Either paid or unpaid interpreters may assist with communications. In all cases:

- A paid interpreter must meet the credentialing standards contained in this policy.
- Persons identified as ineligible to provide services in this policy may not be used even if they are unpaid.
- Persons under age 18 may not interpret for workers or crime victims.

Please review the sections related to eligible and ineligible interpretive services providers.

For paid interpreters, healthcare or vocational providers or their staff must verify services on the Interpretive Services Appointment Record (F245-056-000) or a similar interpreter provider's verification form which will be presented by the interpreter at the end of the appointment. Providers should also note in their records that an interpreter was used at the appointment.

When a procedure requires informed consent, a credentialed interpreter should help you explain the information.

POLICY APPLICATION

This policy applies to interpretive services provided for health care and vocational services in all geographic locations to workers and crime victims having limited English proficiency or sensory impairment; and receiving benefits from the following insurers:

- The State Fund or
- SIEs or
- The Crime Victims Compensation Program.

This policy doesn't apply to interpretive services for workers or crime victims for legal purposes, including but not limited to:

- Attorney appointments
- Legal conferences
- Testimony at the Board of Industrial Insurance Appeals or any court
- Depositions at any level

Payment in these circumstances is the responsibility of the attorney or other requesting party(s).

CREDENTIALS REQUIRED FOR L&I PROVIDER ACCOUNT NUMBER

An interpreter or translator must have an L&I provider account.

To obtain an L&I interpretive services provider account number, an interpreter or translator must:

- Submit credentials using the "Submission of Provider Credentials for Interpretive Services" form (F245-055-000).
- Credentials accepted include those listed below under "Certified Interpreter" and "Certified Translator" or "Qualified Interpreter" or "Qualified Translator".
- Provisional certification isn't accepted.

Interpreters and translators can only be paid for services in the languages for which they have provided credentials.

Credentialed Employees of Health Care and Vocational Providers

Credentialed employees of health care and vocational providers are eligible to receive payment for interpretive services under the following circumstances:

- The individual's sole responsibility is to assist patients or clients with language or sensory limitations and
- The individual is a credentialed interpreter or translator and
- The individual has an L&I provider account number for interpretive services.

Interpreters/Translators Not Eligible for Payment

Other persons may, on occasion, assist the worker or crime victim with language or communication limitations. These persons don't require provider account numbers, but also **won't be paid** for interpretive services. These persons may include but aren't limited to:

- Family members
- Friends or acquaintances
- The healthcare or vocational provider
- Employee(s) of the health care or vocational provider whose primary job isn't interpretation
- Employee(s) of the health care or vocational provider whose primary job is interpretation but who isn't a credentialed interpreter or translator
- Interpreters/translators who don't comply with all applicable state and/or federal licensing or certification requirements, including but not limited to, business licenses as they apply to the specific provider's practice or business

Persons Ineligible to Provide Interpretation/Translation Services

Some persons may not provide interpretation or translation services for workers or crime victims during health care or vocational services delivered for their claims. These persons are:

- The worker's or crime victim's legal or lay representative or any employee of the legal or lay representative
- The employer's legal or lay representative or any employee of the legal or lay representative
- Persons under age 18

NOTE: Workers or crime victims using children for interpretation purposes should be advised they need to have an adult provide these services.

Persons Ineligible to Provide Interpretation/Translation Services at IMEs

Under WAC 296-23-362(3), "The worker may not bring an interpreter to the examination. If interpretive services are needed, the insurer will provide an interpreter." Therefore, at Independent Medical Examinations (IMEs), persons (including interpreter/translator providers with account numbers) who may not provide interpretation or translation services for workers or crime victims are:

- Those related to the worker or crime victim
- Those with an existing personal relationship with the worker or crime victim
- The worker's or crime victim's legal or lay representative or employees of the legal or lay representative
- The employer's legal or lay representative or employees of the legal or lay representative
- Any person who couldn't be an impartial and independent witness
- Persons under age 18

Interpreters and translators located outside of Washington State must submit credentials from their state Medicaid programs, state or national court systems or other nationally recognized programs.

For interpretive services providers in any geographic location, credentials submitted from agencies or organizations other than those listed below may be accepted if the testing criteria can be verified as meeting the minimum standards listed below:

Interpreter test(s) consists of, at minimum:	Document translation test(s) consists of, at minimum:
A verbal test of sight translation in both English and other tested language(s); **and**	A written test in English and in the other language(s) tested; **or**
A written test in English; **and**	A written test and work samples demonstrating the ability to accurately translate from one specific source language to another specific target language
A verbal test of consecutive interpretation in both languages; **and**	
For those providing services in a legal setting, a verbal test of simultaneous interpretation in both languages	

Certified Interpreter

Interpreter who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
Washington State Department of Social and Health Services (DSHS)	Social or Medical Certificate
Washington State Administrative Office for the Courts (AOC)	Certificate
RID-NAD National Interpreter Certification (NIC)	Certified Advanced (Level 2), or Certified Expert (Level 3)
Registry of Interpreters for the Deaf (RID)	Comprehensive Skills Certificate (CSC), or Master Comprehensive Skills Certificate (MSC), or Certified Deaf Interpreter (CID), or Specialist Certificate: Legal (SC:L), or Certificate of Interpretation and Certificate of Transliteration (CI/CT)
National Association for the Deaf (NAD)	Level 4, or Level 5
Federal Court Interpreter Certification Test (FCICE)	Certificate
US State Department Office of Language Services	Verification letter or Certificate

Qualified Interpreter

Interpreter who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
Translators and Interpreters Guild	Certificate
Washington State Department of Social and Health Services (DSHS)	Letter of authorization as a qualified social and/or medical services interpreter
Federal Court Interpreter Certification Examination (FCICE)	Letter of designation or authorization

Certified Translator

Translator who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
DSHS	Translator Certificate
Translators and Interpreters Guild	Certificate
American Translators Association	Certificate

Qualified Translator

Translator who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
A state or federal agency; A state or federal court system; Other organization including language agencies; and/or An accredited academic institution of higher education.	Certificate or other verification showing: Successful completion of an examination or test of written language fluency in both English and in the other tested language(s); and A minimum of 2 years experience in document translation.

Maintaining Credentials

Interpretive services providers are responsible for maintaining their credentials as required by the credentialing agency or organization. Should the interpretive services provider's credentials expire or be removed for cause or any other reason, the provider must immediately notify the insurer.

Hospitals and other facilities may have additional requirements

Hospitals, free standing surgery and emergency centers, nursing homes and other facilities may have additional requirements for persons providing services within the facility. For example, a facility may require all persons delivering services to have a criminal background check, even if the provider isn't a contractor or employee of the facility. The facility is responsible for notifying the interpretive services provider of their additional requirements and managing compliance with the facilities' requirements.

PRIOR AUTHORIZATION

Services not requiring prior authorization

Direct interpretive services (either group or individual) and mileage don't require **prior authorization** on open claims. Providers should check claim status with the insurer prior to service delivery.

Services requested by the insurer or requiring prior authorization

IME Interpretation services

When an IME is scheduled, the insurer or IME provider will arrange for the interpretive services. **Prior authorization** isn't required. The worker may ask the insurer to use a specific interpreter. However, only the interpreter scheduled by the insurer or the IME provider will be paid for IME interpretive services. Interpreters who accompany the worker, without insurer approval, won't be paid or allowed to interpret at the IME.

IME No Shows

Authorization must be obtained prior to payment for an IME no show. For State Fund claims, contact the Central Scheduling Unit supervisor at 206-515-2799, or the SIE/TPA for self-insured claims, after occurrence of IME no show. Per WAC 296-20-010(5) "No fee is payable for missed appointments unless the appointment is for an examination arranged by L&I or self-insurer."

Document translation

Document translation services are only paid when performed at the request of the insurer. Services will be authorized before the request packet is sent to the translators.

COVERED AND NONCOVERED SERVICES

Services that may be payable.

Services prior to claim allowance aren't payable except for the initial visit. If the claim is later allowed, the insurer will determine which services rendered prior to claim allowance are payable.

Only services to assist in completing the reopening application, and for insurer requested IMEs, are payable unless or until a decision is made. If a claim is reopened, the insurer will determine which other services are payable.

Covered and may be billed to the insurer.

Payment is dependent upon service limits and L&I policy:

- Interpretive services which facilitate language communication between the worker and a health care or vocational provider
- Time spent waiting for an appointment that doesn't begin at time scheduled (when no other billable services are being delivered during the wait time)
- Assisting the worker to complete forms required by the insurer and/or health care or vocational provider
- A flat fee for an insurer requested IME appointment plus mileage when the worker doesn't attend
- Translating document(s) at the insurer's request
- Miles driven from a point of origin to a destination point and return

Not covered and may not be billed to nor will they be paid by the insurer:

- Services exceeding 480 minutes per day
- Services provided for a denied or closed claim (except services associated with the initial visit or the visit for the worker's application to reopen a claim)
- No show for any service other than an insurer requested IME (for example, physical therapy visits)
- Mileage for no shows for any service other than an insurer requested IME (for example, physical therapy visits)
- Personal assistance on behalf of the worker such as scheduling appointments,

translating correspondence or making phone calls

- Document translation requested by anyone other than the insurer, including the worker
- Services provided for communication between the worker and an attorney or lay worker representative
- Services provided for communication not related to the worker's communications with health care or vocational providers
- Travel time and travel related expenses such as meals, parking, lodging
- Overhead costs, such as phone calls, photocopying and preparation of bills

FEES, SERVICE DESCRIPTIONS AND LIMITS

The coverage and payment policy for interpretive services is listed below:

Code	Description	Units of Service	Maximum Fee	L&I Authorization and Limit Information
9988M	Group interpretation Direct services time between more than one client and health care or vocational provider, includes wait and form completion time, time divided between all clients participating in group, per minute	1 minute equals 1 unit of service	$0.79 per minute	**Limited to 480 minutes per day** Doesn't require prior authorization
9989M	Individual Interpretation Direct services time between insured and health care or vocational provider, includes wait and form completion time, per minute	1 minute equals 1 unit of service	$0.79 per minute	**Limited to 480 minutes per day** Doesn't require prior authorization
9986M	Mileage, per mile	1 mile equals 1 unit of service	State rate	Mileage billed over 200 miles per claim per day will be reviewed Doesn't require prior authorization
9996M	Interpreter "IME no show" Wait time when insured doesn't attend the insurer requested IME, flat fee	Bill 1 unit per worker no show at IME	Flat fee $52.74 Mileage to and from appointment will also be paid	Payment requires prior authorization Contact Central Scheduling Unit at 260-515-2799 Or the SIE/TPA after no show occurs. Only 1 no show per worker per day
9997M	Document translation, at insurer request	1 page equals 1 unit of service	By report	Authorization will be documented on translation request packet. Over $500 per claim will be reviewed

BILLING FOR INTERPRETIVE SERVICES

Interpretive services providers use the miscellaneous bill form and billing instructions.

Individual Interpretation Services

Services delivered for a single client may include:

- Interpretation performed with the worker and a health care or vocational provider
- Form completion and
- Wait time is time spent waiting for an appointment that doesn't begin at time scheduled (when no other billable services are being delivered during the wait time)

When billing for Individual Interpretation Services:

- Only the time spent actually delivering those services may be billed.
- You must bill all services for the same client, for the same date of service, on one bill to avoid bill denial.
- Time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services ended.
- If there are breaks in service due to travel between places of service delivery, this time must be deducted from the total time billed.

Interpretive Services Appointment Record form http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1625 and mileage verification must be in the claim file at the same time you bill the insurer or your bill may not be paid.

See the Billing Examples, "General Provider Billing Manual" and "Miscellaneous Services Billing Instructions" for further information.

All services provided to a client on the same date must be billed on one bill form or your bills may be denied.

Group Interpretation Services

When interpretive services are delivered for more than 1 person (regardless of whether all are workers and/or crime victims), the time spent must be prorated between the participants.

- Send a separate bill for each client with prorated amounts.

Interpretive Services Appointment Record form http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1625 and mileage verification must be in the claim file at the same time you bill the insurer or your bill may not be paid.

For example, if 3 persons are receiving a 1 hour group physical therapy session at different stations and the interpretive services provider is assisting the physical therapist with all 3 persons:

- The interpretive services provider must bill only 20 minutes per person.
- The time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services end.

See the Billing Examples, "General Provider Billing Manual" and "Miscellaneous Services Billing Instructions" for further information.

The combined total of both individual and group services is limited to 480 minutes (8 hours) per day.

You must send a completed Interpretive Services Appointment Record form http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1625 including the health care or vocational provider's signature, and the mileage verification by the time your bill is processed or your bill may be denied.

IME No Show

Per WAC 296.20.010(5) only services related to No Shows for insurer requested IMEs will be paid. The insurer will pay a flat fee for IME no show. Mileage to and from the IME appointment will also be paid.

Mileage and Travel

Insurers won't pay interpretive service providers' travel time or for travel expenses such as hotel, meals, parking, etc.

Interpretive service providers may bill for actual miles driven to perform interpretation services for an individual client or group of clients. The interpreter must split the mileage between the worker and the next client if this isn't the last appointment of the day.

When mileage is for services to more than 1 person (regardless of whether all are workers and/or crime victims):

- The mileage must be prorated between all the persons served.
- When you interpret for a group, mileage between appointments on the same day should be split between the clients.

Mileage is payable for no show appointments for IME's only.

Send mileage verification to each client's claim file at the same time you bill the insurer or **your bill may not be paid**.

See the Billing Examples, "General Provider Billing Manual" and "Miscellaneous Services Billing Instructions" for further information.

Mileage over 200 miles per day will be reviewed for necessity before being paid.

Document Translation Services

Document translation is an insurer requested service only. Payment for document translation will be made only if the service was requested by the insurer. If anyone other than the insurer requests assistance with document translation, the insurer must be contacted before services can be delivered.

Billing Examples

Example 1 – Individual Interpretive Services

Example Scenario	Time Frames	Type of Service	Code and Units to Bill
Interpreter drives 8 miles from their place of business to the location of an appointment for an worker	Not applicable	Mileage	8 units 9986M
Worker has an 8:45 a.m. appointment. The interpreter and insured enter the exam room at 9:00 a.m. The exam takes 20 minutes. The health care provider leaves the room for 5 minutes and returns with a prescription and an order for X-rays for the insured. The appointment ends at 9:30 a.m.	8:45 a.m. to 9:30 a.m.	Individual Interpretive Services	45 units 9989M
Interpreter drives 4 miles to X-ray service provider and meets insured.	Not applicable	Mileage	4 units 9986M
Interpreter and insured arrive at the radiology facility at 9:45 a.m. and wait 15 minutes for X-rays which takes 15 minutes. They wait 10 minutes to verify X-rays don't need to be repeated.	9:45 a.m. to 10:25 a.m.	Individual Interpretive Services	40 units 9989M
Interpreter drives 2 miles to pharmacy and meets insured.	Not applicable	Mileage	2 units 9986M
The worker and the interpreter arrive at the pharmacy at 10:35 a.m. and wait 15 minutes at the pharmacy for prescription. The interpreter explains the directions to the worker which takes 10 minutes.	10:35 a.m. to 11 a.m.	Individual Interpretive Services	25 units 9989M
After completing the services, the interpreter drives 10 miles to the next interpretive services appointment. The interpreter splits the mileage between the worker and the next client if this isn't the last appointment of the day	Not applicable	Mileage	5 units 9986M

Example 2 – Group Interpretive Services

Example Scenario	Time Frames	Type of Service	Code and units to Bill
Interpreter drives 9 miles from his place of business to the location of an appointment for 3 clients. 2 are insured by the State Fund.	Not applicable	Mileage	3 units of 9986M to each state fund claim
The 3 clients begin a physical therapy appointment at 9:00 a.m. The interpreter circulates between the 3 clients during the appointment which ends at 10 a.m.	9 a.m. to 10 a.m.	Group Interpretive Services	20 units of 9988M to each state fund claim
After completing the appointment the interpreter drives 12 miles to next appointment location. The interpreter splits the mileage between the 3 clients and the next client if this isn't the last appointment of the day (12 divided by 2=6; 6 divided by 3=2).	Not applicable	Mileage	2 units 9986M to each state fund claim

Adjustment vs. Submitting a New Bill for State Fund Claims

- When the whole bill is denied, then you must submit a new bill to be paid.
- When part of the bill is paid, then you must submit an adjustment for the services that were not paid. Additional information on adjustments is available at http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/BillLNI/PayAdjust/default.asp

Billing Tip If the time or mileage needs to be corrected, you should adjust the **last paid** bill.

DOCUMENTATION REQUIREMENTS

Interpretive service appointment and mileage documentation must be submitted to L&I when the services are billed.

Billing Tip Don't staple documentation to bill forms. Send documentation separately from bills for State Fund or Crime Victims Compensation Program claims to:

State Fund
Department of Labor and Industries
PO Box 44291
Olympia, WA 98504-4291
360-902-6500
1-800-848-0811
Fax number:
(360) 902-4567

Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520
360-902-5377
1-800-762-3716

Self-insurer
To determine insurer see the SIE/TPA list at http://www.Lni.wa.gov/ClaimsIns/Providers/billing/billSIEmp/default.asp, or call 360-902-6901.
Send State Fund bills to:
Department of Labor and Industries
PO Box 44269
Olympia, WA 98504-4269

Interpretive Services Appointment Documentation

- Direct interpretive services must be recorded on the Interpretive Services Appointment Record form F245-056-000. Copies can be obtained on L&I's website or a supply of forms can be ordered from the warehouse. Interpretive services providers may also use their own encounter forms to document services, meeting the criteria listed below.
- Provider or agency encounter forms used in lieu of L&I's Interpretive Services Appointment Record **must** have the following information:
  - Claim number, worker's full name, and date of injury in upper right hand corner of form
  - Interpreter name and agency name (if applicable)
  - Encounter (appointment) information including:
  - Health care of vocational provider name
  - Appointment address
  - Appointment date
  - Appointment start time
  - Interpreter arrival time
  - Appointment completion time
  - If a group appointment, total number of clients (not health care or vocational providers) participating in the group appointment
  - Actual mileage information including:
  - Actual miles from starting location (including street address) to appointment
  - Actual miles (not prorated) from appointment to next appointment or return to starting location (include street address)
  - Actual total miles
  - Verification of appointment by health care or vocational provider (Printed name and signature of person verifying services).
  - Date signed

NOTE: All agency encounter and Interpretive Services Appointment Record forms must be signed by the health care or vocational provider or the provider's staff to verify services including mileage for IME no shows.

NOTE: All agency encounter and Interpretive Services Appointment Record forms and mileage verification must be in the claim file before payment is made.

Mileage Documentation

Include mileage documentation that supports the number of miles between appointments. Documentation must be a printout from a software mileage program and name of software program used.

Translation Services Documentation

Documentation for translation services must include:

- Date of service and
- Description of document translated (letter, order and notice, medical records) and
- Total number of pages translated and
- Total words translated and
- Target and source languages.

TELEPHONE INTERPRETIVE SERVICES

Telephone interpretive services are covered when requested by health care providers and vocational counselors through the State of Washington's Western States Contracting Alliance (WSCA) Telephone Based Interpreter Services Contract. Only department preapproved vendors listed in the WSCA contract may provide and be paid for telephone interpretive services. See the below list for preapproved WSCA contracted vendors.

Telephone interpretive services are payable only when the health care or vocational provider has direct (face-to-face) contact with the worker or crime victim.

Credentials required for telephonic interpretive services

Vendor's telephonic interpreter tests will consist of, at minimum:

- Oral fluency in English and other language
- Verbal test of consecutive interpretation in both languages

FEES, SERVICE DESCRIPTIONS AND LIMITS

The coverage and payment policy for telephone interpretive services is listed below:

Code	Description	Units of Service	Maximum Fee	L&I Authorization and Limit Information
9999M	Telephone Interpretation Direct service time between client(s) and health care or vocational provider, per minute	1 minute equals 1 unit of service	Per WSCA contract only*	Payable to L&I preapproved WSCA contracted vendors only Doesn't require prior authorization

***CTS Language Link** fee is **$0.82/minute** for all languages
Pacific Interpreters, Inc. fee is **$0.86/minute** for all languages

WSCA Telephone Based Interpreter Services contract is available at:
https://fortress.wa.gov/ga/apps/ContractSearch/ContractSummary.aspx?c=03508

Prior Authorization

Services not requiring prior authorization

Telephone interpretive services **don't** require **prior authorization** on open claims. Providers should check claim status with the insurer prior to service delivery.

Contracted WSCA vendors

Each vendor must have an active department assigned provider account number.
Providers, both in and out-of-state, who use telephone interpretive services, must use one of the preapproved WSCA contracted vendors.
The approved vendors are:

CTS Language Link	Pacific Interpreters, Inc.
911 Main St., Suite 10 Vancouver, WA 98660 Toll-Free Number: 877-626-0678 Website: http://www.ctslanguagelink.com	707 SW Washington, Suite 200 Portland, OR 97205 Toll-Free Numbers: State Fund Claim: 877-810-4721 Self-Insurance Claim: 877-810-4723 Crime Victims Claim: 877-840-2083 Website: http://pacificinterpreters.com

Telephone Interpretive Services Documentation

- Documentation for telephone interpretive services **must** include:

1. Claim number
2. Worker's/victim's full name
3. Date of injury
4. Interpreter Name and ID Number
5. Language
6. Vendor Name
7. Health care or vocational provider name
8. Appointment address
9. Appointment date
10. Appointment start time
11. Appointment completion time

Billing for Interpretive Services

Bills for telephone interpretive services must be submitted to the appropriate insurer.

For State Fund

Bill State Fund claims electronically.

For Self-insurer

Bill the SIE/TPA using the Statement for Miscellaneous Services bill form, or other form approved by the SIE/TPA.

For Crime Victims

To bill for services, use the Statement for Crime Victim Miscellaneous Services form F245-072-000 available at http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1976 or form CMS 1500.

STANDARDS AND RESPONSIBILITIES FOR INTERPRETIVE SERVICES PROVIDER CONDUCT

L&I is responsible for assuring workers and crime victims receive proper and necessary services. The following requirements set forth the insurer's expectations for quality interpretive services.

RESPONSIBILITIES

Responsibilities toward the Worker and the Health Care or Vocational Provider

The interpreter must ensure that all parties understand the interpreter's role and obligations. The interpreter must:

- Inform all parties that everything said during the appointment will be interpreted and they should not say anything they don't want interpreted.
- Inform all parties the interpreter will respect the confidentiality of the worker.
- Inform all parties the interpreter is required to remain neutral.
- Disclose any relationship to any party that may influence or someone could perceive to influence the interpreter's impartiality.
- Accurately and completely represent their credentials, training and experiences to all parties.

STANDARDS

Accuracy and Completeness

- Interpreters always communicate the source language message in a thorough and accurate manner.
- Interpreters don't change, omit or add information during the interpretation assignment, even if asked by the worker or another party.
- Interpreters don't filter communications, advocate, mediate, speak on behalf of any party or in any way interfere with the right of individuals to make their own decisions.
- Interpreters give consideration to linguistic differences in the source and target languages and preserve the tone and spirit of the source language.

Confidentiality

The interpreter must not discuss any information about an interpretation job without specific permission from all parties or unless required by law. This includes content of the assignment such as:

- Time or place
- Identity of persons involved
- Content of discussions
- Purpose of appointment

Impartiality

- The interpreter must not discuss, counsel, refer, advise or give personal opinions or reactions to any of the parties.
- The interpreter must turn down the assignment if he or she has a vested interest in the outcome, or when any situation, factor, or belief exists that represents a real or potential conflict of interest.

Competency

Interpreters must meet L&I's credentialing standards and be:

- Fluent in English.
- Fluent in the worker's language.
- Fluent in medical terminology in both languages.
- Willing to decline assignments requiring knowledge or skills beyond their competence.

Maintenance of Role Boundaries

- Interpreters must not engage in any other activities that may be thought of as a service other than interpreting, such as:
- Driving the worker to and from appointments
- Suggesting that the worker receive care at certain providers
- Advocating for the worker

Prohibited Conduct

In addition, interpreters can't:

- Market their services to workers or crime victims.
- Arrange appointments in order to:
  - Create business of any kind.
  - Fit into the interpreter's schedule including canceling and rescheduling a worker's medical appointment.
- Contact the worker other than at the request of the insurer or health care or vocational provider.
- Provide transportation for the worker to and from health care or vocational appointments.
- Require the worker to use the interpreter provider's services exclusive of other approved L&I interpreters.
- Accept any compensation from workers or crime victims or anyone else other than the insurer.
- Bill for someone else's services with your individual (not language agency group) provider account number

Tips for Interpretive Services Providers

Some things to keep in mind when working as an interpreter on workers' compensation or crime victims' claims:

- Arrive on time.
- Always provide identification to the worker and providers.
- Introduce yourself to the worker and provider.
- Don't sit with the worker in the waiting room unless assisting him or her with form completion.
- Acknowledge language limitations when they arise and always ask for clarification.
- Don't give your home (nonbusiness) telephone number to the worker or providers.
- Sign up to get L&I provider news and updates at http://www.Lni.wa.gov/Main/Listservs/Provider.asp
- Mail to L&I:
  - Completed Interpreter Services Appointment Record or other qualifying encounter form signed by health care or vocational provider
  - Printout of mileage documentation that supports the number of miles between appointments from a software mileage program and name of software program used

OTHER SERVICES

AFTER HOURS SERVICES

After hours services CPT® codes 99050 - 99060 will be considered for separate payment in the following circumstances:

- When the provider's office isn't regularly open during the time the service is provided.
- When services are provided on an emergency basis, out of the office, that disrupt other scheduled office visits.

After hours service codes aren't payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists and laboratory clinical staff. The medical necessity and urgency of the service must be documented in the medical records and be available upon request.

Only 1 code for after hours services will be paid per worker per day, and a 2nd day may not be billed for a single episode of care that carries over from 1 calendar day to the next.

LOCUM TENENS

- Modifier –Q6 denotes services furnished by a locum tenens physician.
- Modifier –Q6 **isn't covered** and L&I **won't pay** for services billed under another provider's account number.

L&I requires all providers to obtain a provider account number to be eligible to treat workers and crime victims and receive payment for services rendered. Refer to WAC 296-20-015 for more information about the requirements.

MEDICAL TESTIMONY AND DEPOSITIONS

The Office of the Attorney General or the SIE makes arrangements with expert witnesses to provide testimony or deposition. Bills for these services should be submitted directly to the Office of the Attorney General or the SIE. Although L&I doesn't use codes for medical testimony, SIEs must allow providers to use CPT® code 99075 to bill for these services. State Fund utilizes a separate voucher A19 form which will be provided to you by the Office of the Attorney General, thus providers shouldn't use the CPT® code and L&I can't provide prepayment for any of these services.

Fees are calculated on a portal-to-portal time basis (from the time you leave your office until you return), but don't include side trips.

The time calculation for testimony, deposition or related work performed in the provider's office or by phone is based upon the actual time used for the testimony or deposition.

The medical witness fee schedule is set by law, which requires any provider having examined or treated a worker must abide by the fee schedule and testify fully, irrespective of whether paid and called to testify by the Office of the Attorney General or the self-insurer. The Office of the Attorney General or the self-insurer and the provider must cooperate to schedule a reasonable time for the provider's testimony during business hours. Providers must make themselves reasonably available for such testimony within the schedule set by the Board of Industrial Insurance Appeals.

The Office of the Attorney General provides a medical provider testimony fee schedule when testimony is scheduled. No service will be paid in advance of the date it is provided. Requests for a nonrefundable amount will be denied. Any exceptions to the fee schedule will be on a case by case basis.

The party requesting interpretive services for depositions or testimony is responsible for payment.

Testimony and Related Fees (applied to doctors as defined in WAC 296-20-01002)

Description	Maximum Fee
Medical testimony (live or by deposition)	$ 100.00/unit* (Maximum of 17 units)
Record review	$ 100.00/unit* (Maximum of 25 units)
Conferences (live or by telephone)	$ 100.00/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	$ 100.00/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Testimony and Related Fees (applied to all other health care providers)

Description	Maximum Fee
Medical testimony (live or by deposition)	$ 22.50/unit* (Maximum of 17 units)
Record review	$ 22.50/unit* (Maximum of 25 units)
Conferences (live or by telephone)	$ 22.50/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	$ 22.50/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Testimony and Related Fees (applied to vocational providers)

Description	Maximum Fee
Medical testimony (live or by deposition), regular vocational services Medical testimony (live or by deposition), forensic vocational services	$ 22.50/unit* $26.25/unit* (Maximum of 17 units)
Record review, regular vocational services Record review, regular vocational services, forensic vocational services	$ 22.50/unit* $26.25/unit* (Maximum of 25 units)
Conferences (live or by telephone), regular vocational services Conferences (live or by telephone), forensic vocational services	$ 22.50/unit* $26.25/unit* (Maximum of 9 units)
Travel , regular vocational services Travel, forensic vocational services (Paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	$ 22.50/unit* $26.25/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Testimony and Related Fees (applied to all out-of-state doctors as defined in WAC 296-20-01002)

Description	Maximum Fee
Medical testimony (live or by deposition)	$ 125.00/unit* (Maximum of 17 units)
Record review	$ 125.00/unit* (Maximum of 25 units)
Conferences (live or by telephone)	$ 125.00/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	$ 125.00/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent.

Cancellation policy for testimony or depositions

Cancellation Date	Cancellation Fee
3 working days or less than 3 working days notice before a hearing or deposition	Attorney General/SIE **will pay** a cancellation fee for the amount of time you were scheduled to testify, at the allowable rate.
More than 3 working days notice before a hearing or deposition	Attorney General/SIE **won't pay** a cancellation fee.

NURSE CASE MANAGEMENT

All nurse case management (NCM) services require **prior authorization** by the claim manager or ONC. Contact the insurer to make a referral for NCM services.

Workers with catastrophic work related injuries, and/or workers who have moved out-of-state and need assistance locating a provider, and/or workers with medically complex conditions may be selected to receive NCM services.

NCM is:

- A collaborative process used to meet worker's health care and rehabilitation needs.
- Provided by registered nurses:
- With case management certification.
- Aware of resources in the worker's location.

The nurse case manager works with the attending provider, worker, allied health personnel, and insurers' staff to assist in locating a provider and/or with coordination of the prescribed treatment plan. Nurse case managers organize and facilitate timely receipt of medical and health care resources and identify potential barriers to medical and/or functional recovery of the worker. They communicate this information to the attending doctor, claim manager, or ONC to develop a plan for resolving or addressing the barriers.

Nurse case managers must use the following local codes to bill for NCM services, including nursing assessments:

Code	Description	Maximum Fee
1220M	Phone calls, per 6 minute unit	$ 9.64
1221M	Visits, per 6 minute unit	$ 9.64
1222M	Case planning, per 6 minute unit	$ 9.64
1223M	Travel/Wait, per 6 minute unit (16 hour limit)	$ 4.74
1224M	Mileage, per mile – greater than 600 miles requires prior authorization from the claim manager	State rate
1225M	Expenses (parking, ferry, toll fees, cab, lodging and airfare) at cost or state per diem rate (meals and lodging). Requires prior authorization from the claim manager ($725 limit)	By report

NCM services are capped at 50 hours of service, including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases, contingent upon review by the insurer.

Billing Units Information

- Units are whole numbers and not tenths units.
- Each traveled mile is 1 unit service.
- Each 6 minutes of phone calls, visits, case planning, or travel/wait time is 1 unit of service.
- Each related travel expense is 1 unit of service.

Minutes = # of Units	Minutes = # of Units
6 = 1	36 = 6
12 = 2	42 = 7
14 = 3	48 = 8
24 = 4	54 = 9
30 = 5	60 = 10

Non-covered expenses include:

- Nurse case manager training
- Supervisory visits
- Postage, printing and photocopying (except medical records requested by L&I)
- Telephone/fax
- Clerical activity (e.g. faxing documents, preparing documents to be mailed, organizing documents, etc.)
- Travel time to post office or fax machine
- Wait time exceeding 16 hours
- Fees related to legal work, for example, deposition, testimony. Legal fees may be charged to the requesting party, but not the claim
- Any other administrative costs not specifically mentioned above

Case Management Records and Reports

Case management records must be created and maintained on each claim. The record shall present a chronological history of the worker's progress in NCM services.

Case notes shall be written when a service is given and shall specify:

- When the service was provided, and
- What type of service was provided using case note codes, and
- Description of the service provided including subjective and objective data, and
- How much time was spent providing each service.

NCM reports shall be completed monthly. Payment will be restricted to up to 2 hours for initial reports and up to 1 hour for progress and closure reports. For additional information about billing, refer to the "Miscellaneous Services Billing Instructions". Contact the Provider Hotline at 1-800-848-0811 to request a copy.

Report Format

Initial assessment, monthly, progress, and closure reports must include **all** of the following information:

- Type of report (initial or progress)
- Worker name and claim number
- Report date and reporting period
- Worker date of birth and date of injury
- Contact information
- Diagnoses
- Reason for referral
- Present status/current medical
- Recommendations
- Actions and dates
- Ability to positively impact a claim
- Health care provider(s) name(s) and contact information
- Psychosocial/economic issues
- Vocational profile
- Amount of time spent completing the report
- Hours incurred to date on the referral

REPORTS AND FORMS

Providers should use the following CPT® or local codes to bill for special reports or forms required by the insurer. The fees listed below include postage for sending documents to the insurer:

Code	Report/Form	Max Fee	Special notes
CPT® 99080	60-Day Report	$ 43.51	60-day reports are required per WAC 296-20-06101 and don't need to be requested by the insurer. Not payable for records required to support billing or for review of records included in other services. Limit of 1 per 60 days per claim.
CPT® 99080	Special Report (Requested by insurer or VRC)	$ 43.51	**Must be requested by insurer or vocational counselor.** Not payable for records or reports required to support billing or for review of records included in other services. Don't use this code for forms or reports with assigned codes. Limit of 1 per day.
1027M	Loss of Earning Power (LEP)	$ 18.93	**Must be requested by insurer.** Payable only to attending provider. Limit of 1 per day.
1040M	Report of Industrial Injury or Occupational Disease/ Report of Accident (ROA) – for State Fund claims	$ 37.84	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim.
1040M	Provider's Initial Report – for Self Insured claims	$ 37.84	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim.

Code	Report/Form	Max Fee	Special notes
1041M	Application to Reopen Claim	$ 49.18	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. May be initiated by the worker or insurer (see WAC 296-20-097). Limit of 1 per request.
1055M	Occupational Disease History Form	$ 183.56	**Must be requested by insurer.** Payable only to attending provider. Includes review of worker information and preparation of report on relationship of occupational history to present condition(s).
1057M	Opioid Progress Report Supplement or any standardized objective tool to evaluate pain and function	$ 30.27	Payable only to attending provider. Paid when the worker is prescribed opioids for chronic, non-cancer pain. Must be submitted at least every 60 days. See WACs 296-20-03021, -03022 and the Labor and Industries Medical Treatment Guidelines. Limit of 1 per day.
1063M	Attending Doctor Review of Independent Medical Exam (IME)	$ 37.84	**Must be requested by insurer.** Payable only to attending provider. Limit of 1 per request.
1064M	Initial report documenting need for opioid treatment	$ 56.77	Payable only to the attending provider. Paid when initiating opioid treatment for chronic, non-cancer pain. See WAC 296-20-03020 and the Labor and Industries Medical Treatment Guidelines for what to include in the report.
1065M	Attending Doctor IME Written Report	$ 28.37	**Must be requested by insurer.** Payable only to attending provider when submitting a separate report of IME review. Limit of 1 per request.
1066M	Provider Review of Video Materials with report	By report	**Must be requested by insurer.** Payable once per provider per day. Report must include actual time spent reviewing the video materials. Not payable in addition to CPT® code 99080 or local codes 1104M or 1198M.
1073M	Insurer Activity Prescription Form (APF)	$49.18	**Must be requested by** insurer or vocational rehabilitation counselor (VRC). Payable once per provider per worker per day. Exception: APF may accompany the ROA/PIR
1074M	AP response to VRC/Employer request about RTW	$30.27	For written communication with VRCs and employers. Team conference, office visit, telephone call, or online communication with a VRC or employer can't be billed separately.

More information on some of the reports and forms listed above is provided in WAC 296-20-06101. Many L&I forms are available and can be downloaded from http://www.Lni.wa.gov/FormPublications/ and all reports and forms may be requested from the Provider Hotline at 1-800-848-0811. When required, the insurer will send special reports and forms.

COPIES OF MEDICAL RECORDS

Providers may bill for copies of medical records requested by the insurer using HCPCS code S9982. Payment for S9982 includes all costs, including taxes and postage. S9982 isn't payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

Only providers who have provided health care or vocational services to the worker may bill HCPCS code S9982. The insurer will pay for requested copies of medical records, regardless of whether the provider is currently treating the worker or has treated the worker at some time in the past, including prior to the injury. If the insurer requests records from a health care provider, the insurer will pay for the requested services. Payment will be made per copied page.

S9982 ..... $0.48

PROVIDER MILEAGE

Providers may bill for mileage when a round trip exceeds 14 miles. This code requires **prior authorization** and usage is limited to extremely rare circumstances.

Code	Description	Max Fee
1046M	Mileage, per mile, allowed when round trip exceeds 14 miles	$4.86

REVIEW OF JOB OFFERS AND JOB ANALYSES

Attending providers must review the physical requirements of any job offer submitted by the employer of record and determine whether the worker can perform that job. Whenever the employer asks, the attending provider should send the employer an estimate of physical capacities or physical restrictions and review each job offer submitted by the employer to determine whether or not the worker can perform that job.

A **job offer** is based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis. For more information about job offers, see RCW 51.32.09(4).

A **job description** is an employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

A **job analysis (JA)** is a detailed evaluation of a specific job or type of job. A JA is used to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience, nonwork related skills and physical limitations or to determine the worker's ability to perform a specific job. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

Attending providers, independent medical examiners and consultants will be paid for review of job descriptions or JAs. A job description/JA review may be performed at the request of the employer, the insurer, vocational rehabilitation counselor (VRC), or TPA. Reviews requested by other persons (for example, attorneys or workers) won't be paid. This service doesn't require prior authorization if a vocational referral has been made. However, it does require authorization in any other circumstance. This service is payable in addition to other services performed on the same day.

A **provisional JA** is a detailed evaluation of a specific job or type of job requested when a claim has not been accepted. This service requires **prior authorization** and won't be authorized during an open vocational referral. A provisional JA must be conducted in a manner consistent with the requirements in WAC 296-19A-170. The provider assigned to or directly receiving the authorization from the referral source is responsible for all work performed by any individual on the job analysis.

Code	Report/Form	Max Fee	Special notes
1038M	Review of Job Descriptions or JA	$ 49.18	**Must be requested by insurer, employer or vocational counselor.** Payable to attending provider, IME examiner or consultant. Limit of 1 per day. Not payable to IME examiner on the same day as the IME is performed. .
1028M	Review of Job Descriptions or JA, each additional review	$ 36.89	**Must be requested by insurer, employer or vocational counselor.** Payable to attending provider, IME examiner or consultant. Bill to L&I. For IME examiners on day of exam: may be billed for each additional JA after the first 2. For IME examiners after the day of exam: may be billed for each additional JA after the initial (initial is billed using 1038M).

VEHICLE AND HOME MODIFICATIONS

Refer to WAC 296-14-6200 through WAC 296-14-6238 for home modification information. A home modification consultant must be a licensed registered nurse, occupational therapist or physical therapist and trained or experienced in both rehabilitation of catastrophic injuries and in modifying residences. Additional information is available at:

http://www.lni.wa.gov/ClaimsIns/Voc/BackToWork/JobMod/Default.asp

A vehicle modification consultant must be a licensed occupational or physical therapist, or licensed medical professional with training or experience in rehabilitation and vehicle modification.

Code	Description	Maximum Fee
8914H	Home modification, construction and design. Requires **prior authorization** based on approval by the assistant director of Insurance Services	Maximum payable for all work is the current Washington state average annual wage.
8915H	Vehicle modification. Requires **prior authorization** based on approval by the assistant director of Insurance Services	Maximum payable for all work is ½ the current Washington state average wage. The amount paid may be increased by no more than $4,000 by written order of the Supervisor of Industrial Insurance RCW 51.36.020(8b).
8916H	Home modification evaluation and consultation. Requires **prior authorization**	By report
8917H	Home/vehicle modification mileage, lodging, airfare, car rental. Requires **prior authorization**	State rate
8918H	Vehicle modification, evaluation and consultation. Requires **prior authorization**	By report
0391R	Travel/wait time per 6 minutes. Requires **prior authorization**	$4.83

JOB MODIFICATIONS AND PRE-JOB ACCOMMODATIONS

This benefit provides funding to modify a job or retraining site to accommodate a restriction related to the industrial injury.

- In some cases, the department may reimburse for consultation services.
- The need for a job modification or pre-job accommodation must be identified and documented by L&I, the attending healthcare provider, treating occupational or physical therapist, employer, worker, or vocational rehabilitation counselor.
- Job modification and pre-job accommodations must be preauthorized. Consultations pertaining to a specific job modification or pre-job accommodation must be pre-authorized after the need has been identified. (See b above).

The provider of a job modification or pre-job accommodation consultation must be a licensed occupational therapist or physical therapist, vocational rehabilitation provider, or ergonomic specialist.

Pre-job accommodation benefits are only available for state fund claims. However, self-insured employers may cover these costs for self-insured claims.

The following codes are payable to:

- Physical therapists
- Occupational therapists
- Ergonomic specialists
- Vocational rehabilitation counselors not associated with the group assigned to the vocational referral
-
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Code	Description	Activities	Maximum Fee
0389R	Pre-job or job modification consultation, analysis of physical demands (non-VRC), per 6 minutes. Requires prior authorization	Consultation time with worker Composing the report Communication Instruction in work practices When indicated: • Obtains bids • Completes and submits assistance application packet Analysis of job physical demands to assist a VRC in completing a job analysis (qualified PT or OT only)	$ 10.66
0391R	Travel/wait time (non-VRC), per 6 minutes. Requires prior authorization	Traveling to work/training site as part of direct consultation services	$ 4.83
0392R	Mileage (non-VRC), per mile. Requires prior authorization	Mileage to work/training site as part of direct consultation services	State rate
0393R	Ferry Charges (non-VRC). Requires prior authorization	If required to travel to work/training site as part of direct consultation services	State rate

Vocational rehabilitation counselors and interns in the group assigned to the vocational referral must bill these services using procedure codes 0823V and 0824V. See Vocational Evaluation on page **176**.

If services are provided to a worker with an open vocational referral, see Vocational Evaluation and Related Codes for additional information for non-vocational providers on page **178**.

Services Not Billable

- Performing vocational rehabilitation services as described in WAC 296-19A on claims with open vocational referrals.
- Activities associated with reports other than composing or dictating complete draft of the report (for example, editing, filing, distribution, revising, typing, and mailing).
- Time spent on any administrative and clerical activity, including typing, copying, faxing, mailing, distributing, filing, payroll, recordkeeping, delivering mail, picking up mail.

The following codes are payable to authorized equipment vendors:

Code	Description	Activities	Maximum Fee
0380R	Job modification Requires **prior authorization**	Equipment/Tools • Installation • Set up • Basic training in use • Delivery (includes mileage) • Tax • Custom Modification/Fabrication Work area modification/reconfiguration	Maximum allowable for 0380R is $5,000 per job or job site.
0385R	Pre-job accommodation Requires **prior authorization**	Equipment/Tools • Installation • Set up • Basic training in use • Delivery (includes mileage) • Tax • Custom Modification/Fabrication Work/Training area modification/reconfiguration	Maximum allowable for 0385R is $5,000 per claim. Combined costs of 0380R and 0385R for the same return to work goal can't exceed $5,000.

Consultants may supply the equipment/tools only if:

- Custom design and fabrication of unique equipment or tool modification is required, and,
- Prior authorization is obtained, and
- Proper justification and cost estimates are provided.

Additional information is available at
http://www.Lni.wa.gov/ClaimsIns/Providers/Vocational/Tools/PreJob/default.asp

VOCATIONAL SERVICES

Vocational services providers must use the codes listed in this section to bill for services. For more detailed information on billing, consult the Miscellaneous Services Billing Instructions (F248-095-000). Maximum fees apply equally to both State Fund and self-insured vocational services.

BILLING CODES BY REFERRAL TYPE

All vocational services require **prior authorization**. Vocational services are authorized by referral type. The State Fund uses 6 referral types.

- Early intervention
- Assessment
- Plan development
- Plan implementation
- Forensic
- Stand alone job analysis

Each referral is a separate authorization for services. Insurers will pay interns at 85% of the Vocational Rehabilitation Counselor (VRC) professional rate and forensic evaluators at 120% of the VRC professional rate. All referral types except forensic are subject to a fee cap (per referral) in addition to the maximum fee per unit. See fee caps, page **179** for more information.

Early Intervention

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0800V	Early Intervention Services (VRC)	$ 8.77
0801V	Early Intervention Services (Intern)	$ 7.47
0802V	Early Intervention Services Extension (VRC)	$ 8.77
0803V	Early Intervention Services Extension (Intern)	$ 7.47

Assessment

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0810V	Assessment Services (VRC)	$ 8.77
0811V	Assessment Services (Intern)	$ 7.47

Vocational Evaluation, Job and Pre-job Modification Consultation

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0821V	Vocational Evaluation (VRC)	$ 8.77
0823V	Pre-job or Job Modification Consultation (VRC)	$ 8.77
0824V	Pre-job or Job Modification Consultation (Intern)	$ 7.47

Plan Development

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0830V	Plan Development Services (VRC)	$ 8.77
0831V	Plan Development Services (Intern)	$ 7.47

Plan Implementation

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0840V	Plan Implementation Services (VRC)	$ 8.77
0841V	Plan Implementation Services (Intern)	$ 7.47

Forensic Services

The VRC assigned to a forensic referral must directly perform ALL the services needed to resolve the vocational issues and make a supportable recommendation.

Exception: Vocational evaluation services may be billed by a third party, if authorized by the insurer.

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0881V	Forensic Services (Forensic VRC)	$ 10.50

Stand Alone Job Analysis

The codes in this table are used for stand alone and provisional job analyses. For State Fund claims, this referral type is limited to 15 days from the date the referral was electronically created by the claim manager. Bills for dates of service beyond the 15th day will not be paid.

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0808V	Stand Alone Job Analysis (VRC)	$ 8.77
0809V	Stand Alone Job Analysis (Intern)	$ 7.47
0378R	Stand Alone Job Analysis (non-VRC)	$ 8.77

Other billing codes

Travel, Wait Time, and Mileage

Code	Description	Maximum Fee
0891V	Travel/Wait Time (VRC or Forensic VRC) 1 unit = 6 minutes	$ 4.38
0892V	Travel/Wait Time (Intern) 1 unit = 6 minutes	$ 4.38
0893V	Professional Mileage (VRC) 1 unit = 1 mile	State rate
0894V	Professional Mileage (Intern) 1 unit = 1 mile	State rate
0895V	Air Travel (VRC, Intern, or Forensic VRC)	By report
0896V	Ferry Charges (VRC, Intern or Forensic VRC)	By report
0897V	Hotel Charges (VRC, Intern or Forensic VRC) out-of-state only	By report

Travel/Mileage Billing

The insurer pays for work performed by providers on vocational referrals only from the branch office where the referral was assigned. The insurer **doesn't pay** for travel time or mileage between two different service locations or branch offices where a provider is working cases. Providers may bill from the branch office where the referral was assigned by the VRC to necessary destinations. Examples include: going to the location of the employer of record, visiting an attending physician's office and the meeting of a VRC with an injured worker at the worker's home. For out of state cases, VRC may only bill from the branch office nearest the worker.

Special Services, Nonvocational Providers

L&I established a procedure code to be used for special services provided during Assessment Plan Development, and Plan Implementation, for example: commercial driver's license (CDL), physicals, background checks, driving abstracts and fingerprinting.

The code must be billed by a medical or a miscellaneous nonphysician provider on a miscellaneous services billing form. The referral ID and referring vocational provider account number must be included on the bill. Limit 1 unit per day, per claim.

The code requires **prior authorization**. For State Fund claims, VRCs must contact the vocational services specialist (VSS) to arrange for prior authorization from the claim manager. For self-insured claims, contact the SIE/TPA for prior authorization.

The code can't be used to bill for services that are part of a retraining plan (registration fees or supplies) that might be purchased prior to the plan.

Code	Description	Maximum Fee
0388R	Plan , providers	By report

Vocational Evaluation and Related Codes for Nonvocational Providers

Certain nonvocational providers may deliver the above services with the following codes:

Code	Description	Maximum Fee
0389R	Pre-job or Job Modification Consultation, 1 unit = 6 minutes	$ 10.66
0390R	Vocational Evaluation, 1 unit = 6 minutes	$ 8.77
0391R	Travel/Wait (non-VRC), 1 unit = 6 minutes	$ 4.83
0392R	Mileage (non-VRC), one unit = 1 mile	State rate
0393R	Ferry Charges (non-VRC)(1)	State rate

(1) Requires documentation with a receipt in the case file.

A provider can use the **R** codes if he or she is a:

- Nonvocational provider such as an occupational or physical therapist, or
- Vocational provider delivering services for a referral assigned to a different payee provider. As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider account number than you), you can't bill as a vocational provider (provider type 68). You must either use another provider account number that is authorized to bill the ancillary services codes (type 34, 52 or 55) or obtain a miscellaneous services provider account number (type 97) and bill the appropriate codes for those services.

NOTE: These providers use the miscellaneous services billing form, but must include certain additional pieces of information on bills to associate the costs of ancillary services to the vocational referral and to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider, and
- The service provider ID for the assigned vocational provider in the "Name of physician or other referring source" box at the top of the form, and
- Nonvocational provider's own provider account numbers at the bottom of the form.

FEE CAPS

Vocational services are subject to fee caps. The following fee caps are by referral. All services provided for the referral are included in the cap. Travel, wait time and mileage charges aren't included in the fee cap for any referral type.

Description	Applicable Codes	Maximum Fee
Early Intervention Referral Cap, per referral	0800V, 0801V	$1,801.00
Assessment Referral Cap, per referral	0810V, 0811V	$3,003.00
Plan Development Referral Cap, per referral	0830V, 0831V	$6,014.00
Plan Implementation Referral Cap, per referral	0840V, 0841V	$6,818.00
Stand Alone Job Analysis Referral Cap, per referral	0808V, 0809V, 0378R	$ 459.00

The fee cap for vocational evaluation services applies to multiple referral types.

Description	Applicable Codes	Maximum Fee
Work Evaluation Services Cap	0821V, 0390R	$1,316.00

For example, if $698.00 of work evaluation services is paid as part of an ability to work assessment (AWA) referral, only the balance of the maximum fee is available for payment under another referral type.

Referrals that Reach the Fee Cap

Fee cap requirements:

- The vocational provider must track costs associated with their referrals to assure the fee cap isn't exceeded
- When a fee cap is reached, vocational providers aren't required to continue to provide services over and above the fee cap without payment. However, providers must notify the VSS or SIE/TPA of the situation. Providers must continue to deliver services as required by WAC 296-19A until the cap is reached.
- Providers must comply with all requirements in WAC 296-19A with regard to closing referrals, including submitting a closing report, even if the claim manager has closed the referral.
- Providers shouldn't enter any closure outcome with their closing report. Only the CM can enter the ADM7 closure code for fee cap reached.
- Vocational providers must not recommend the claim manager close a referral with an alternative closure code to avoid reaching the fee cap. After closing a referral due to reaching a fee cap, any subsequent referral of the same type may not be assigned to the same vocational counselor.
- Early Intervention Fee Cap Extension
- For early intervention referrals, a provider may request an extension of the fee cap in cases of **medically approved** graduated return to work (GRTW) or work hardening (WH) opportunities. The extension is for **1 time only per claim** and doesn't create a new referral. The extension is limited to a maximum of 20 hours of service over a maximum of 12 weeks. Providers should submit bills for these services in the same format as other vocational bills. The claim manager must authorize the extension. No other early intervention professional services (for example, services billed using 0800V and 0801V) may be provided once the extension has been approved. You may continue to bill for travel/wait, mileage and ferry charges as normal. Use codes 0802V and 0803V to bill for GRTW and WH services provided during the extension.
-

Description	Applicable Codes	Maximum Fee
Extension of Early Intervention Referral Cap, once per claim	0802V, 0803V	$ 1,756.00

Fee Cap Exceptions for AWAs and Plan Implementation Referrals

- Exception codes must be used to authorize an extra number of billable hours. Any use of these exception codes requires prior authorization by the VSS for State Fund claims, or by the SIE/TPA for self-insured claims.
- For AWA referrals, 2 new exception codes are available with an additional fee cap of $877.00.

Code	Description	Maximum Fee
0812V	Assessment Services Exception (VRC)	$ 8.77 per 6 minutes
0813V	Assessment Services Exception (Intern)	$ 7.47 per 6 minutes

- For Plan Implementation referrals, 2 new exception codes are available with an additional fee cap of $2,026.00.

Code	Description	Maximum Fee
0842V	Plan Implementation Services Exception (VRC)	$ 8.77 per 6 minutes
0843V	Plan Implementation Services Exception (Intern)	$ 7.47 per 6 minutes

Fee-Cap Exception Request

The vocational provider assigned to the referral may request additional time:

- Within 2 hours ($175.00) of reaching the fee cap; and

NOTE: Extra time isn't available if the original cap has been reached.

- Plan must demonstrate that the extra time will allow for resolution of the referral; and
- Referrals must have started on or after January 1, 2008

Denial of Request

The vocational provider must follow department policy on referrals that reach the fee cap.

Approval of Request

- The vocational provider may bill the exception code up to the additional cap.
- Once the added cap has been reached, the provider exhausts the original fee cap.

NOTE: Extra time isn't available if the original cap has been reached.

Not Complete After Fee-Cap Exception

The provider must follow department policy on referrals that reach the fee cap.

ADDITIONAL REQUIREMENTS

ADMA Billing

Vocational providers may use ADMA outcome-- VRC declines referral--for up to 14 days after the referral assignment. This outcome is to be used when VRC determines that the referral isn't appropriate. Examples include:

- Conflict of interest
- Not ready for a referral due to medical issues, etc

Prior to entering an ADMA outcome, VRC needs to contact the claims manager to discuss the reasons for declining the referral.

A maximum of three professional hours may be billed for reviewing the file and preparing a brief rationale, using the standard VCLOS routing sheet.

Preferred Worker Certification for workers who choose Option 2

Vocational providers must consider assisting a worker in obtaining Preferred Worker Certification whenever it is appropriate. This includes a worker who has an approved plan, but has decided to choose Option 2.

Vocational providers can bill for assisting workers with obtaining Preferred Worker Certification for up to 14 days after an Option 2 selection has been made.

Insurer Activity Prescription Form (APF), 1073M

Only the insurer or VRC can request that a health care provider complete an Insurer APF. For State Fund claims, healthcare providers will not be paid for APFs requested by employers or attorneys. A VRC may request an APF from the provider if clarification or updated physical capacity information is needed or a worker's condition has changed.

- Employers can obtain physical capacity information by:
- Using completed APFs available on the department's Claim and Account Center at http://www.Lni.wa.gov/ORLI/LoGon.asp, or
- Requesting an APF through the claim manager when updated physical capacity information is needed.

Other Requests for Return-to-Work Information

Health care providers may bill 1074M for written responses to employer requests regarding return-to-work issues. Examples include:

- Concurrence with performance based physical capacities evaluation (PBPCE)
- Authorization for worker to participate in PBPCE
- Job modification or pre-job modification reviews
- Proposed work hardening program
- Plan for graduated, transitional, return to work

Vocational Evaluation

Vocational evaluation can be used during an assessment referral to help determine a worker's ability to benefit from vocational services when a recommendation of eligibility is under consideration. Vocational evaluation may also be used during a plan development referral to assist a worker in identifying a viable vocational goal. Vocational evaluation may include:

- Psychometric testing
- Interest testing
- Work samples
- Academic achievement testing
- Situational assessment
- Specific and general aptitude and skill testing

When a vocational provider obtains a vocational evaluation, the provider must ensure that the test administration, interpretation and reporting of results are performed in a manner consistent with assessment industry standards.

Vocational providers, provider type 68, must use procedure code 0821V to bill for vocational evaluation services.

Use code 0821V for the formal testing itself, or for a meeting that is *directly* related to explaining the purposes or findings of testing.

Non-vocational providers must use procedure code 0390R. Bill using the miscellaneous billing form and include the:

- Vocational referral ID obtained from the assigned vocational provider, and
- Service provider ID for the assigned vocational provider in the "Name of the physician or other referring source" box at the top, and
- Non-vocational provider's individual provider account number at the bottom of the form.

For example, a school receives a referral from a VRC for basic achievement testing. After administering the testing, the school must:

- Use the miscellaneous billing form and
- Obtain the vocational referral ID number from the VRC and place on the billing form and
- Obtain the VRC's service provider number and place in the "Name of the physician or other referring source" box at the top, and
- Place the school's provider account number at the bottom of the form.

Retraining Plans that Exceed Statutory Benefit Limit

- The VSS will only approve vocational retraining plans that have total costs and time that are within the statutory retraining benefit limit.
- The VSS won't approve a plan with costs that exceed the statutory benefit even if the worker has access to other funding sources. Vocational providers may not develop or submit such a plan.

How Multiple Providers Who Work on a Single Referral Bill for Services

Multiple providers may deliver services on a single referral if they have the **same** payee provider account number. This situation might occur when interns assist on referrals assigned to VRCs, or where 1 provider covers the caseload of an ill provider. When more than 1 provider works on a referral, each provider must bill separately for services delivered on the referral; and each provider must use:

- His/her individual provider account number,
- The payee provider account number and
- The referral ID.

If several providers work on a single referral, the assigned provider is ultimately responsible for the referral. The performance data associated with that referral accrues to the **assigned** provider's performance rating.

Split Billing across Multiple Referrals

When a worker has 2 or more open time-loss claims, State Fund may make a separate referral for each claim. In cases where State Fund makes 2 (or more) concurrent referrals for vocational services, State Fund will specify if the vocational provider is to split the billing.

When billing for vocational services on multiple referrals and/or claims, follow these instructions:

1. Split billable hours over a larger interval of work (up to the entire billing date span), rather than per each single activity.

   Example: Provider XYZ has 2 open referrals for the same worker. If the provider bills once a week, one approach would be to total all the work done with that worker on both referrals in a day, or in the entire week, then divide by 2.

2. Bills must be split equally, in whole units, charging the same dollar amount on each claim/referral.

3. If, after totaling all work done during the billing period, the total is still not an even number of units, round to the nearest even whole number of units, then divide by 2 as directed above.

4. If split bills don't contain the same number of units, they will be denied and must be rebilled in the correct format. If there are 3 (or more) claims requiring time-loss compensation and vocational services, the vocational rehabilitation bills are to be split accordingly (3 claims = by thirds, 4 claims = by fourths), based on the number of concurrent referrals received.

Vocational providers must document multiple referrals and split billing for audit purposes.

Referral Resolution

A vocational referral initially made to a firm, and then assigned to a VRC must close if the same VRC is no longer available to provide services. Referrals made directly to the VRC may be transferred by the claim manager to the VRC's new firm, only if the VRC has already *established a relationship with a new firm within the same service location*, via the Vocational Provider Account Application process.

Vocational providers **must** notify the insurer if the VRC assigned to a referral is no longer available to provide services on that referral. Following are guidelines for notifying the insurer:

Example 1:

For referrals made to the firm and assigned to a VRC:

- It is the responsibility of the assigned VRC to close the referral on Voc Link Connect with the outcome, "VRC no longer available". This outcome must be entered immediately on the VRC's change in status.
- It is the responsibility of the vocational manager of the firm to notify the claim manager(s) of the change in status for that referral. State Fund must be notified by telephone and/or fax within 3 working days of the change in status. Notification by the vocational manager isn't necessary if the VRC assigned to the referrals successfully closes the referral as noted above.

The VRC assigned to the referral(s) **may not** contact the claim manager(s) for the purpose of informing them of a change in employment. This would be considered marketing, which is prohibited by department policy. The resolution (for example, re-referral) of the referral is at the sole discretion of the claim manager.

Example 2:

For referrals made directly to the VRC:

- The VRC is responsible for notifying the claim manager of his/her new status, and should be prepared to inform the claim manager of the payee provider account number of the new firm, as well as the VRC's new service provider account number associated with that firm
- The claim manager, at his/her sole discretion, may transfer the referral(s) to the VRC at the new firm, provided that the VRC is available to work in the same service location in which the original referral was made

Appropriate Timing of *VocLink Connect* Outcome Recommendations for State Fund Claims

State Fund has established clear expectations regarding the submission of closing reports at the conclusion of a vocational referral.

Vocational providers use *VocLink Connect* to enter an outcome recommendation at the conclusion of work on a referral. The VRC must complete the report before a *VocLink* outcome recommendation is made to State Fund. The paper report should be submitted to L&I at the same time that the outcome recommendation is made. The report is considered part of the referral, which isn't complete until the report is done.

There are some circumstances when an outcome recommendation is made, and no report is required. Examples include "VRC no longer available" and "VRC declines referral".

In all other cases, the paper report must be submitted to State Fund at the same time the recommendation is made.

Submitting a Vocational Assessment or Retraining Plan for Self-Insured Claims

- What is the Self-Insurance Vocational Reporting Form? (See: WAC 296-15-4302)
- What must the self-insurer do when an assessment report is received? (WAC 296-15-4304)
- When must a self-insurer submit a vocational rehabilitation plan to the department? (WAC 296-15-4306)
- What must the vocational rehabilitation plan include? (WAC 296-15-4308)
- What must the self-insurer do when the department denies the vocational rehabilitation plan? (WAC 296-15-4310)
- What must the self-insurer do when the vocational rehabilitation plan is successfully completed? (WAC 296-15-4312)
- What must the self-insurer do if the vocational rehabilitation plan isn't successfully completed? (WAC 296-15-4314(5))

Responsibilities of Service Providers and Firms in Regard to Changes in Status

NOTE: Change in status responsibilities apply to both State Fund and self-insurance vocational providers.

The insurer must be notified immediately by both the firm and the service provider (VRC or intern) when there is a change in status. Changes in status include:

- VRC or intern ends their association with a firm.
- VRC assigned to a referral is no longer available to provide services on the referral(s).
- Firm closes.

Notification to L&I requires:

1. Resolution of the open referral(s) and
2. Submission of the Vocational Provider Change Form(s) to Private Sector Rehabilitation Services (L&I, PO Box 44326, Olympia WA 98504-4326).

These forms may be found at L&I's vocational services web site http://www.lni.wa.gov/ClaimsIns/Voc/WorkWithLni/Provider/Default.asp.

A firm or service provider that fails to notify L&I of changes in status may be in violation of WAC and/or L&I policy. This may result in L&I issuing findings and subsequent corrective action(s) as described in WAC 296-19A-260 and WAC 296-19A-270.

Approved Plan Services that Occur Prior to the Plan Start Date

The following are services/fees that the insurer may cover prior to a plan start date and outlines the procedure for adjudicating bills for dates of service prior to a plan start date.

- Registration fees billed as retraining tuition, R0310.
- Rent, food, utilities and furniture rental. (Payment for these items may be made up to 29 days prior to a plan start date to allow a worker to move and get settled before training starts.)

These services require **prior authorization** by the insurer.

Bills for services incurred prior to a plan start date won't be paid prior to the date L&I formally approves the plan.

Retraining travel, R0330, **isn't payable** prior to a plan start date. Travel that occurs prior to a plan start date is generally to a jobsite to evaluate whether a particular job goal is reasonable, or to a school to pay for registration, books or look over the campus. These types of trips aren't part of a retraining plan and should be billed by the worker under V0028. Travel to appointments with the VRC should also be billed under V0028.

Selected Plan Procedure Code Definitions

L&I has defined the following retraining codes:

- R0312 Retraining supplies are consumable goods such as:
  - Paper
  - Pens
  - CDs
  - Disposable gloves
- R0315 Retraining equipment, tools such as:
  - Calculator
  - Software
  - Survey equipment
  - Welding gloves & hood
  - Bicycle repair kits
  - Mechanics tools
- R0350 Other, includes professional uniforms, including uniform shoes, required for training, and other items that don't fit the more defined categories. Items purchased using R0350 must be for vocational rehabilitation retraining.

The insurer doesn't have the authority to purchase glasses, hearing aids, dental work, clothes for interviews, or other items as a way to remove barriers during retraining.

Reimbursement for Food

The insurer reimburses for food including grocery and restaurant purchases made while the worker is participating in an approved plan.

The vocational provider must review charges for these expenses for inappropriate items (for example, personal items, alcohol, paper and cleaning products, tobacco, pet food, etc.) and to ensure each date of purchase is itemized on the bill. Charges for food, combined in weekly or monthly date spans, **aren't allowed**. Each food purchase must be listed on a separate bill line for each date food is purchased. Receipts are always required for any item(s) purchased by the worker. Copies of receipts are acceptable. The provider and/or the worker should also retain a copy of receipts.

The worker won't be reimbursed over the monthly-allowed per diem amount. It is the vocational provider's responsibility to monitor the bills to ensure the worker doesn't exceed their monthly allotment for food.

The vocational provider will review the receipts, deduct personal and other noncovered items and sign the Statement for Retraining and Job Modification Services form.

Once the vocational provider signs the Statement for Retraining and Job Modification Services form the insurer will assume the provider has reviewed the bill and receipts, removed inappropriate charges and has verified the charges are within the worker's per diem allotment for that month.

Mileage on Transportation Cost Encumbrance

The insurer reimburses mileage only in whole miles. Calculate mileage point to point, rounding each planned trip up to the nearest whole mile.

Questions regarding completion of the Transportation Cost Encumbrance form should be referred to the VSS.

Facility Services

This section contains payment policies and information for facility services.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules* (MARFS) and Provider Bulletins.

If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with MARFS, L&I's rules and policies take precedence

(See WAC 296-20-010).

All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

FACILITY SERVICES TABLE OF CONTENTS

HOSPITAL PAYMENT POLICIES

HOSPITAL PAYMENT POLICIES OVERVIEW

Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury. Hospital payment policies established by L&I are reflected in Chapters 296-20, 296-21, 296-23 and 296-23A WAC and in the Hospital Billing Instructions. No copayments or deductibles are required or allowed from workers.

HOSPITAL BILLING REQUIREMENTS

All charges for hospital inpatient and outpatient services provided to workers must be submitted on the UB-04 billing form using the UB-04 National Uniform Billing Committee Data Element Specifications. Hospitals are responsible for establishing criteria to define inpatient and outpatient services. Bills for patients admitted and discharged the same day, however, may be treated as outpatient bills and may be paid via a POAC rate.

For State Fund claims, inpatient bills will be evaluated according to L&I's Utilization Review Program. Inpatient bills submitted to L&I without a treatment authorization number may be selected for retrospective review. For observation services, L&I will follow CMS guidance. For a current copy of the Hospital Billing Instructions, contact the L&I Provider Hotline at 1-800-848-0811.

HOSPITAL ACQUISITION COST

Any item covered under the acquisition cost policy will be paid using a hospital specific percent of allowed charges (POAC). Non-hospital facilities will be paid a statewide average POAC.

HOSPITAL INPATIENT ACUTE CARE PAYMENT INFORMATION

Self-insured Payment Method

Services for hospital inpatient care provided to workers covered by Self-insurers are paid using hospital specific POAC factors for all hospitals (see WAC 296-23A-0210).

Crime Victims Compensation Program Payment Method

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using DSHS POAC factors (see WAC 296-30-090).

State Fund Payment Methods

Services for hospital inpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

1. An All Patient Diagnosis Related Group (AP DRG) system. See WAC 296-23A-0470 for exclusions and exceptions. L&I currently uses AP DRG Grouper version 23.0.
2. A statewide per diem rate for those AP DRGs that have low volume or for inpatient services provided in Washington rural hospitals.
3. A POAC rate for hospitals excluded from the AP DRG system.

The following tables provide a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Inpatient Acute Care Services
Hospitals not in Washington	Paid by an out-of-state POAC factor. Effective **July 1, 2011** the rate is **57.8%.**
Washington excluded Hospitals: • Children's Hospitals • Health Maintenance Organizations (HMOs) • Military Hospitals • Veterans Administration • State Psychiatric Facilities	Paid 100% of allowed charges.
• Washington Major Teaching Hospitals; • Harborview Medical Center • University of Washington Medical Center	Paid on a per case basis for admissions falling within designated AP DRGs.(1) For low volume AP DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP DRG categories: • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical
All other Washington Hospitals	Paid on a per case basis for admissions falling within designated AP DRGs.(1) For low volume AP DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP DRG categories: • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical

(1) See http://feeschedules.Lni.wa.gov for the current AP DRG Assignment List.

Hospital Inpatient Acute Care AP DRG Base Rates

Effective **July 1, 2011** the AP DRG Base Rates

Hospital	Base Rate
Harborview Medical Center	**$11,055.17**
University of Washington Medical Center	**$9,725.63**
All Other Washington Hospitals	**$9,244.08**

Hospital Inpatient Acute Care AP DRG Per Diem Rates

Effective **July 1, 2011** the AP DRG per diem Rates are as follows:

Payment Category	Rate(1)	Definition
Psychiatric AP DRG Per Diem	**$888.39** Multiplied by the number of days allowed by L&I. Payment won't exceed allowed billed charges.	AP DRGs 424-432
Chemical Dependency AP DRG Per Diem	**$733.32** Multiplied by the number of days allowed by L&I. Payment won't exceed allowed billed charges.	AP DRGs 743-751
Rehabilitation AP DRG Per Diem	**$1,532.58** Multiplied by the number of days allowed by L&I. Payment won't exceed allowed billed charges.	AP DRG 462
Medical AP DRG Per Diem	**$2,108.32** Multiplied by the number of days allowed by L&I. Payment won't exceed allowed billed charges.	AP DRGs identified as medical
Surgical AP DRG Per Diem	**$4,131.83** Multiplied by the number of days allowed by L&I. Payment won't exceed allowed billed charges.	AP DRGs identified as surgical

(1) For information on how specific rates are determined see Chapter 296-23A WAC. The AP DRG Assignment List with AP DRG codes and descriptions and length of stay is in the fee schedules section and is available online at http://feeschedules.Lni.wa.gov.

Additional Inpatient Acute Care Hospital Rates

Payment Category	Rate	Definition
Transfer-out Cases	Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the AP DRGs average length of stay. If the worker's stay is less than the average length of stay, a per-day rate is established by dividing the AP DRG payment amount by the average length of stay for the AP DRG. Payment for the first day of service is 2 times the per-day rate. For subsequent allowed days, the basic per-day rate will be paid. If the worker's stay is equal to or greater than the average length of stay, the AP DRG payment amount will be paid.	A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge.
Low Outlier Cases (costs are less than the threshold)	Hospital Specific POAC Factor multiplied by allowed billed charges.	Cases where the cost (1) of the stay is less than 10% of the statewide AP DRG rate or **$581.63**, whichever is greater.
High Outlier Cases (costs are greater than the threshold)	AP DRG payment rate plus 100% of costs in excess of the threshold.	Cases where the cost (1) of the stay exceeds **$17,446.32** or 2 standard deviations above the statewide AP DRG rate, whichever is greater.

(1) Costs are determined by multiplying the allowed billed charges by the hospital specific POAC factor.

HOSPITAL OUTPATIENT PAYMENT INFORMATION

Self-insured Payment Method

Services for hospital outpatient care provided to workers covered by self-insurers are paid using facility-specific POAC factors or the appropriate Professional Services Fee Schedule amounts (see WAC 296-23A-0221).

Crime Victims Compensation Program Payment Method

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using either DSHS POAC factors or the Professional Services Fee Schedule (see WAC 296-30-090).

State Fund Payment Methods

Services for hospital outpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

1. Outpatient Prospective Payment System (OPPS) using an Ambulatory Payment Classification (APC) system. See Chapter 296-23A WAC (Section 4), WACs 296-23A-0220, 296-23A-0700 through 296-23A-0780 for a description of L&I's OPPS system.
2. An amount established through L&I's Professional Services Fee Schedule for items not covered by the APC system
3. POAC for hospital outpatient services not paid by either the APC system or with an amount from the Professional Services Fee Schedule

The following table provides a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Outpatient Services
Hospitals not in Washington State	Paid by an out-of-state POAC factor. Effective **July 1, 2011** the rate is **57.8%**
Washington Excluded Hospitals: • Children's Hospitals • Military Hospitals (1) • Veterans Administration • State Psychiatric Facilities	Paid 100% of allowed charges
• Rehabilitation Hospitals • Cancer Hospitals • Critical Access Hospitals • Private Psychiatric Facilities	Paid a facility-specific POAC or Fee Schedule amount depending on procedure
All other Washington Hospitals	Paid on a per APC (2) basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility-specific POAC(1).

(1) Military hospitals may bill HCPCS code T1015 for all outpatient clinic services.
(2) Hospitals will be sent their individual POAC and APC rates each year.

Pass-Through Devices

A transitional pass-through device is an item accepted for payment as a new, innovative medical device by CMS where the cost of the new device has not already been incorporated into an APC. Hospitals will be paid fee schedule or if no fee schedule exists, a hospital-specific POAC for new or current pass-through devices. New or current drug or biological pass-through items will be paid by fee schedule or POAC (if no fee schedule exists).

Hospital OPPS Payment Process

Question	Answer	Payment Method
1. Does L&I cover the service?	No	Don't Pay
	Yes	Go to question 2
2. Does the service coding pass the Outpatient Code Editor (OCE) edits?	No	Don't Pay
	Yes	Go to question 3
3. Is the procedure on the inpatient-only list?	No	Go to question 4
	Yes	Pay POAC(1)
4. Is the service packaged?	No	Go to question 5
	Yes	Don't Pay, but total the Costs for possible outlier(2) consideration. Go to question 7.
5. Is there a valid APC?	No	Go to question 6
	Yes	Pay the APC amount and total payments for outlier(2) consideration. Go to question 7.
6. Is the service listed in a Fee Schedule?	No	Pay POAC
	Yes	Pay the Facility Amount for the service
7. Does the service qualify for outlier?(1)	No	No outlier payment
	Yes	Pay outlier amount(3)

(1) If only 1 line item on the bill is inpatient (IP), the entire bill will be paid POAC.
(2) Only services packaged or paid by APC are used to determine outlier payments.
(3) Outlier amount is in addition to regular APC payments.

OPPS Relative Weights and Payment Rates

The relative weights used by CMS will be used for the OPPS program. Each hospital's blended per-APC rate was determined using a combination of the average hospital-specific per APC rate and the statewide average per APC rate. Additional information on the formulas used to establish individual hospital rates can be found in WAC 296-23A-0720. Hospitals will receive notification of their blended per-APC rate via separate letter from L&I or by accessing http://feeschedules.Lni.wa.gov and going to the hospital rates link.

OPPS Outlier Payments

L&I follows the current CMS outlier payment policy. See the most current federal register for a complete description of the policy.

AMBULATORY SURGERY CENTER PAYMENT POLICIES

GENERAL INFORMATION

Information about L&I's ambulatory surgery center (ASC) requirements can be found in Chapter 296-23B WAC.

WHO MAY BILL FOR ASC SERVICES

An ASC is an outpatient facility where surgical services are provided and that meets the following 3 requirements:

1. Must be licensed by the state(s) in which it operates, unless that state doesn't require licensure;
2. Must have at least 1 of the following credentials:
    a. Medicare Certification as an ambulatory surgery center or
    b. Accreditation as an ambulatory surgery center by a nationally recognized agency acknowledged by the Centers for Medicare and Medicaid Services (CMS) and
3. Must have an active ASC provider account with L&I.

BECOMING ACCREDITED OR MEDICARE CERTIFIED AS AN ASC

Providers may contact the following organizations for information:

National Accreditation

American Association for Accreditation of Ambulatory Surgery Facilities
5101 Washington Street, Suite #2F
PO BOX 9500 Gurnee, IL 60031
888-545-5222; www.aaaasf.org/

Accreditation Association for Ambulatory Health Care
3201 Old Glenview Rd., Suite 300
Wilmette, IL 60091
847-853-6060; www.aaahc.org/

American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611
800-621-1773; www.osteopathic.org/

Commission on Accreditation of Rehabilitation Facilities
4891 East Grant Road
Tucson, AZ 85712
888-281-6531; http://www.carf.org/

Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
630-792-5862; www.jcaho.org/

Medicare Certification

Department of Health
Office of Health Care Survey
Facilities and Services Licensing
PO BOX 47852
Olympia, WA 98504-7852
360-236-2905; e-mail: fslhhhacs@doh.wa.gov
Web: www.doh.wa.gov/hsqa/fsl/HHHACS_home.htm

Please note it may take 3-6 months to get certification or accreditation.

ASC PAYMENTS FOR SERVICES

The insurer pays the lesser of the billed charge (the usual and customary fee) or L&I's maximum allowed rate.

L&I's rates are based on a modified version of the current system developed by Medicare for ASC services.

ASC Procedures Covered for Payment

L&I uses the CMS list of procedures covered in an ASC plus additional procedures determined to be appropriate. All procedures covered in an ASC are listed online at: http://feeschedules.Lni.wa.gov

L&I expanded the list that CMS established for allowed procedures in an ASC. L&I added some procedures CMS identified as excluded procedures.

ASC Procedures Not Covered for Payment

Procedures not listed in the ASC fee schedule section of MARFS aren't covered in an ASC.

ASCs won't receive payment for facility services for minor procedures that are commonly done in an office setting or treatment room. See the next paragraph for exceptions to this policy. The provider performing these procedures may still bill for the professional component.

Process to Obtain Approval for a Noncovered Procedure

Under certain conditions, the director, the director's designee or self-insurer, at their sole discretion, may determine that a procedure not on L&I's ASC procedure list may be authorized in an ASC. For example, this may occur when a procedure could be harmful to a particular patient unless performed in an ASC. Requests for coverage under these special circumstances require prior authorization.

The health care provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. The written request must contain:

- A description of the proposed procedure with associated CPT® or HCPCS procedure codes,
- The reason for the request,
- The potential risks and expected benefits and
- The estimated cost of the procedure.

The healthcare provider must provide any additional information about the procedure requested by the insurer.

ASC BILLING INFORMATION

Modifiers Affecting Payment for ASCs

–50 Bilateral Procedures

Modifier –50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each procedure performed. Modifier –50 must be applied to the second line item. The second line item will be paid at **50%** of the allowed amount for that procedure.

–51 Multiple Procedures

Modifier –51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. Modifier –51 should be applied to the second line item. The total payment equals the sum of:

> **100%** of the maximum allowable fee for the highest valued procedure according to the fee schedule, plus
> **50%** of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

If the same procedure is performed on multiple levels the provider must bill using separate line items for each level.

–52 Reduced Services

Modifier –52 identifies circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier –52, signifying that the service is reduced.

Beginning July 1, 2008 a **50%** payment reduction will be applied for discontinued radiology procedures and other procedures that don't require anesthesia (ASCs should use modifier –52 to report such an occurrence).

–73 Discontinued procedures prior to the administration of anesthesia

Modifier –73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

–74 Discontinued procedures after administration of anesthesia

Modifier –74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

–99 Multiple modifiers

Modifier –99 must be used when more than four modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes only, modifier –99 must go in the modifier column with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

BRAIN INJURY REHABILITATION SERVICES

Billing for Separate Services and Therapies

The brain injury rehabilitation services policy is being revised. Until the new policy is written, and upon approval by an ONC or SIE/TPA, individual services and therapies can be done separately through outpatient services when the provider submits a coordinated plan of care. Services can include but aren't limited to:

- Psychotherapy services
- Speech therapy
- Medical services
- Neural therapy
- Occupational therapy

Providers wishing to bill and be paid using the current L&I brain injury local codes must follow the policy and meet the qualifications and conditions listed below:

Qualified Providers

Only providers approved by the insurer can provide post-acute brain injury rehabilitation services for workers. When a complete course of evaluation and treatment is required, L&I requires providers treating a patient on a State Fund claim to submit that plan to

Department of Labor & Industries
Provider Accounts Unit
PO Box 44261
Olympia, WA 98504-4261

Special L&I Provider Account Number Required

Providers participating in the Brain Injury Program must have a special provider account number if they have CARF accreditation to treat and bill for a complete course of evaluation and treatment. Providers may request a provider application or find out if they have a qualifying provider account number by calling the Provider Hotline at 1-800-848-0811.

NOTE: Billing for State Fund claims: Providers participating in the Brain Injury Program must bill for brain injury rehabilitation services using the special post-acute brain injury rehabilitation program provider account number assigned by L&I. Providers billing for individual services and therapies don't need to obtain a special provider account number.

QUALIFYING PROGRAMS

Post-acute brain injury rehabilitation programs must include the following phases:

- Evaluation
- Treatment
- Follow-up

AUTHORIZATION REQUIREMENTS

Prior authorization is required for post-acute brain injury rehabilitation evaluation and treatment. For State Fund claims, cases requiring post-acute brain injury rehabilitation will be reviewed by the ONCs and by L&I claim managers prior to making a determination or authorization. The Provider Hotline can't authorize brain injury treatment.

An ONC and an L&I claim manager will separately review a brain injury claim to determine whether prior authorization will be granted. The Provider Hotline can advise if a prior authorization has been entered into the L&I claim system.

For self-insured claims, contact the SIE/TPA for authorization.
http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

Approval Criteria

Before a worker can receive treatment all of the following conditions must be met:

- The insurer has allowed brain injury as an accepted condition under the claim; and
- The brain injury is related to the industrial injury or is retarding recovery; and
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program; and
- The screening evaluation done by the brain injury program demonstrates the worker is capable of new learning following the brain injury; and
- The screening evaluation report by the program identifies specific goals to help the worker improve function or accommodate for lost function.

Comprehensive Brain Injury Evaluation Requirements

A Comprehensive Brain Injury Evaluation must be performed for all workers who are being considered for inpatient services or for an outpatient post-acute brain injury rehabilitation treatment program. This evaluation is multidisciplinary and contains an in-depth analysis of the workers mental, emotional, social and physical status and functioning.

The evaluation must be provided by a multidisciplinary team that includes a

- Medical physician,
- Psychologist,
- Vocational rehabilitation specialist,
- Physical therapist,
- Occupational therapist,
- Speech therapist and
- Neuropsychologist.

Additional medical consultations are referred through the program's physician. For State Fund claims, each consultation may be billed under the provider account number of the consulting physician. Services must be **preauthorized** by an L&I claim manager or the self-insured employer.

BILLING INFORMATION

Tests Included in the Comprehensive Brain Injury Program Evaluation

The following tests and services are included in the price of performing a Comprehensive Brain Injury Program Evaluation and **may not be billed separately**. They may be performed in any combination depending on the workers condition

- Neuropsychological Diagnostic Interview(s), testing and scoring
- Initial consultation and exam with the program's physician
- Occupational and Physical Therapy evaluations
- Vocational Rehabilitation evaluation
- Speech and language evaluation
- Comprehensive report

Preparatory Work Included in the Comprehensive Brain Injury Program Evaluation

The complementary and/or preparatory work that may be necessary to complete the Comprehensive Brain Injury Evaluation is considered part of the provider's administrative overhead. It includes but isn't limited to:

- Obtaining and reviewing the workers historical medical records
- Interviewing family members, if applicable
- Phone contact and letters to other providers or community support services
- Writing the final report
- Office supplies and materials required for service(s) delivery

Therapies Included in the Treatment

The following therapies, treatments and/or services are included in the Brain Injury Program maximum fee schedule amount for the full-day or half-day brain injury rehabilitation treatment and **may not be billed separately:**

- Physical therapy and occupational therapy
- Speech and language therapy
- Psychotherapy
- Behavioral modification and counseling
- Nursing and health education and pharmacology management
- Group therapy counseling
- Activities of daily living management
- Recreational therapy (including group outings)
- Vocational counseling
- Follow-up interviews with the worker or family, which may include home visits and phone contacts

Preparatory Work Included in Treatment

Ancillary work, materials and preparation that may be necessary to carry out Brain Injury Program functions and services that are considered part of the provider's administrative overhead and aren't **payable separately** include, but aren't limited to:

- Daily charting of patient progress and attendance
- Report preparation
- Case management services
- Coordination of care
- Team conferences and interdisciplinary staffing
- Educational materials (for example, workbooks and tapes)

Follow Up Included in Treatment

Follow up care is included in the cost of the full day or half day program. This includes, but isn't limited to:

- Telephone calls
- Home visits
- Therapy assessments

THERAPY ASSESSMENTS DOCUMENTATION REQUIREMENTS

The following documentation is required of providers when billing for post-acute brain injury rehabilitation treatment programs:

- Providers are required to keep a daily record of a workers attendance, activities, treatments and progress
- All test results and scoring must also be kept in the workers medical record. Records should also include:
  - Documentation of interviews with family and
  - Any coordination of care contacts (for example, phone calls and letters) made with providers or case managers not directly associated with the facility's program
- Progress reports should be sent to the insurer regularly, including all preadmission and discharge reports

FEES

Non-Hospital Based Programs

The following local codes and payment amounts for nonhospital based outpatient post-acute brain injury rehabilitation treatment programs are effective **July 1, 2011**.

Code	Description	Maximum Fee
8950H	Comprehensive brain injury evaluation	$4,297.53
8951H	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	$974.87
8952H	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	$678.97

Hospital Based Programs

The following revenue codes and payment amounts for hospital based outpatient post-acute brain injury rehabilitation treatment programs are effective **July 1, 2011**.

Code	Description	Maximum Fee
0014	Comprehensive brain injury evaluation	$4,297.53
0015	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	$974.87
0016	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	$678.97

NURSING HOME, RESIDENTIAL, HOSPICE AND SUB ACUTE CARE SERVICES

COVERED SERVICES

The insurer covers proper and necessary residential care services that require 24-hour institutional care to meet the worker's needs, abilities and safety. The insurer will also cover medically necessary hospice care comprising of skilled nursing care and custodial care for the worker's accepted industrial injury or illness.

P**rior authorization** is required by an L&I ONC or the self-insured employer.

Services must be:

- Proper and necessary and
- Required due to an industrial injury or occupational disease and
- Requested by the attending physician and
- Authorized by an L&I ONC or self-insured employer before care begins.

Facilities

Qualifying providers are DSHS or DOH licensed and authorized facilities providing residential services for 24-hour institutional care including:

- Skilled Nursing Facilities (SNF)
- Nursing Homes (NH)
- Transitional Care Units (TCU) that are independent and licensed by DOH or who are doing business as part of a Nursing Home or Hospital and are **covered** by the license of the Nursing Home or Hospital
- Critical Access Hospitals (CAHs) licensed by DOH using swing beds to provide sub acute care
- Adult Family Homes/Boarding Homes including
  - Assisted Living Facilities
  - Adult Residential Care
  - Enhanced Adult Residential Care
- Hospice care providers

For industrial injury claims, providers must have the staff and equipment available to meet the needs of the injured workers.

NONCOVERED SERVICES

Services in adult day care centers **aren't covered** by L&I or by self insurers.

AUTHORIZATION REQUIREMENTS

Initial Admission

Residential care services require **prior authorization**. To receive payment, providers must notify the insurer when they agree to provide residential care services for a worker.

Only an L&I ONC can authorize residential care services for State Fund claims. The ONC authorizes an initial length of stay based on discussions with the facility's admissions coordinator.

For authorization procedures on a self-insured claim, contact the self-insurer directly.

Nursing Facilities. Nursing facilities and transitional care units must complete a Minimum Data Set (MDS) Basic Assessment Tracking Form for the worker within 10 working days of admission. Forms are available from CMS.

MDS 2.0:

http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#TopOfPage

MDS 3.0:

http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage

This form or similar instrument will also determine the appropriate L&I payment group. The same schedule as required by Medicare should be followed when performing the MDS reviews.

Failure to assess the worker or report the appropriate payment group to an L&I ONC or the self-insured employer may result in delayed or reduced payment. This requirement applies to all lengths of stay.

L&I has forms available that can be substituted for MDS forms. Forms F245-052-000, for use with MDS 2.0, and F245-392-000, for use with MDS 3.0, are available at

http://www.lni.wa.gov/FormPub/results.asp?Keyword=Provider%20Billing

Adult Family Homes, Boarding Homes and Assisted Living Facilities.

At the insurers' request, a Long Term Care Assessment Tool must be completed by an independent Registered Nurse (RN) within 10 days of admission. The tool will determine the appropriate L&I payment grouping. Failure to complete the assessment tool may result in delayed or reduced payment. An assessment must be completed at least once per year after the initial assessment.

The tool is available at

http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=2345

Critical Access Hospitals Using Swing Beds for Sub Acute Care

As of July 1, 2011, critical access hospitals will be paid for swing bed services utilizing a hospital specific POAC rate.

You may contact an occupational nurse consultant (ONC) for approval. To obtain information for contacting an ONC, call the provider hotline at 800-831-5227.

Upon approval from a Labor & Industries ONC, critical access hospitals should bill their customary charge for sub acute care (swing bed use) on the UB-04 billing form. Identify these services in the Type of Bill Field (Form Locator 04) with 018x series (hospital swing beds).

When Care Needs Change

If the needs of the worker change, a new assessment must be completed and communicated to an L&I ONC or the self-insured employer.

If the initial length of stay needs to be extended, or if the severity of the workers condition changes, contact an L&I ONC or the self-insured employer for re-authorization of the workers care.

Find contact information for self-insured claims at:

http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/Default.asp

BILLING INFORMATION

Billing Requirements

Providers beginning treatment on a workers' compensation claim on or after January 1, 2005 will use the fee schedule or new daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this section.

The primary billing procedures applicable to residential facility providers can be found in WAC 296-20-125, Billing procedures.

All Residential Care Services should be billed on form F245-072-000 Statement for Miscellaneous Services found at http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=1627

Pharmaceuticals and Durable Medical Equipment

Residential facilities **can't bill** for pharmaceuticals or DME. Pharmaceuticals and DME required to treat the worker's accepted condition must be billed by a pharmacy or DME supplier.

Billing Tip

Inappropriate use of CPT® and HCPCS codes may delay payment. For example, billing drugs or physical therapy using DME codes is improper coding and will delay payment while being investigated.

REVIEW OF RESIDENTIAL SERVICES

The insurer may perform periodic independent nursing evaluations of residential care services provided to workers. Evaluations may include, but aren't limited to, on-site review of the worker and review of medical records.

All services rendered to workers are subject to audit by L&I. See RCW 51.36.100 and RCW 51.36.110.

FEES

Negotiated payment arrangements; Insurers with existing negotiated arrangements:

Code	Description	Maximum Fee
8902H	Negotiated payment arrangements	By report

NOTE: Insurers with existing negotiated arrangements made prior to January 1, 2005 may continue their current arrangements and continue to use code 8902H until the worker's need for services no longer exists or the worker is transferred to a new facility.

Hospice Care

Hospice claims are paid on a by report basis. Occupational, physical and speech therapies are included in the daily rate and aren't separately payable. Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Programs must bill the following HCPCS codes:

Code	Abbreviated Description	Maximum Fee
Q5003	Hospice Care Prov in Nrsng Lng-Trm Care Facility	By report
Q5004	Hospice Care Prov in Skill Nursing Facility	By report
Q5005	Hospice Care Prov in Inpatient Hospital	By report
Q5006	Hospice Care Prov in Inpatient Hospice Facility	By report
Q5007	Hospice Care Prov in Lng Trm Care Facility	By report
Q5008	Hospice Care Prov in Inpatient Psychiatric Facility	By report
Q5009	Hospice Care Prov in Place NOS	By report

Boarding Homes, Assisted Living Facilities and Adult Family Homes

For dates of service **July 1, 2011** or after:

The numeric score determined by the Long Term Care Assessment Tool will determine which billing code to use. The payment rates below are daily payment rates.

Billing Code	Description	Assessment Score	Maximum Fee
8893H	L&I RF Low	6 - 20	$161.60
8894H	L&I RF Medium	21 - 36	$196.23
8895H	L&I RF High	37 - 57	$230.86

These three levels of care will be applied to all non nursing home facility types. Don't bill for the assessments. The RNs conducting the assessments will bill the insurer separately.

The tool is available at

http://www.Lni.wa.gov/FormPub/Detail.asp?DocID=2345

Nursing Home, Transitional Care Unit and Swing Bed Fees

L&I uses a modified version of the skilled nursing facility prospective payment system for developing the residential facility payment system.

The fee schedule for Nursing Home beds, Transitional Care Unit beds and swing beds is a series of daily facility payment rates including room rates, therapies and nursing components depending on the needs of the worker. Medications aren't included in the L&I rate.

Fee Schedule – NH, TCU and Swing Beds Effective **July 1, 2011**

Billing Code	Description	Included Medicare RUG Groups	Maximum Fee
		REHAB GROUPS	
8880H	Rehab-Ultra High	RUX, RUL, RUC, RUB, RUA	$646.57
8881H	Rehab-Very High	RVX, RVL, RVC, RVB, RVA	$484.37
8882H	Rehab-High	RHX, RHL, RHC, RHB, RHA	$451.47
8883H	Rehab-Medium	RMX, RML, RMC, RMB, RMA	$417.36
8884H	Rehab-Low	RLX, RLB, RLA	$325.47
		NURSING SERVICES GROUPS	
8885H	Extensive Services	ES3, ES2, ES1	$403.96
8886H	Special Care High	HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1	$300.90
8887H	Special Care Low	LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1	$299.26
8888H	Clinically Complex	CE2, CE1, CD2, CD1, CC2, CC1, CB2, CB1, CA2, CA1	$220.75
8889H	Behavioral Symptoms and Cognitive Performance	BB2, BB1, BA2, BA1	$219.12
		REDUCED PHYSICAL FUNCTION GROUPS	
8890H	Reduced Physical Function	PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1	$230.86

CHRONIC PAIN MANAGEMENT

COVERAGE DECISION

Injured workers eligible for benefits under Title 51 RCW may be evaluated for and enrolled in a comprehensive treatment program for chronic noncancer pain if it meets the definition of a structured, intensive, multidisciplinary program (SIMP). Prior authorization is required for all workers to participate in a SIMP for functional recovery from chronic pain.

Special conditions and requirements apply to workers who are considering having a lumbar fusion or lumbar intervertebral artificial disc replacement due to uncomplicated degenerative disc disease (referred to as lumbar surgery candidates as defined in WAC 296-20-12065). These conditions and requirements are noted throughout this policy.

Lumbar surgery candidates must successfully complete a SIMP to obtain authorization for a lumbar fusion or a lumbar intervertebral artificial disc replacement.

GOALS

The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic noncancer pain.

POLICY INFORMATION

Portions of this policy are supported by WAC 296-20-12055 through WAC 296-20-12095.

Definitions

Defined terms throughout this bulletin are noted in *italics*.

The following definitions apply to this policy:

SIMP: means a chronic pain management program with the following four components:

Structured means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed health care practitioners. Workers follow a *treatment plan* designed specifically to meet their needs.

Intensive means the Treatment Phase is delivered on a daily basis, 6-8 hours per day, 5 days per week, for up to 4 consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs.

Multidisciplinary (interdisciplinary) means that structured care is delivered and directed by licensed health care professionals with expertise in pain management in *at least* the areas of medicine, psychology, and physical therapy or occupational therapy. The SIMP may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits.

Program means an interdisciplinary pain rehabilitation program that provides outcome-focused, coordinated, goal-oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

Uncomplicated Degenerative Disc Disease (UDDD) means chronic low back pain of discogenic origin without objective clinical evidence of any of the following conditions:

- Radiculopathy;
- Functional neurologic deficits;
- Spondylolisthesis (> Grade 1);
- Isthmic spondylolysis;
- Primary neurogenic claudication associated with stenosis;
- Fracture, tumor, infection, inflammatory disease; or
- Degenerative disease associated with significant deformity.

Lumbar surgery candidate means an injured worker who is considering having a lumbar fusion or lumbar intervertebral artificial disc replacement due to uncomplicated degenerative disc disease.

Important Associated Conditions means medical or psychological conditions (often referred to as co-morbid conditions) that hinder functional recovery from chronic pain.

Treatment Plan means an individualized plan of action and care developed by licensed health care professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and addresses the elements described in the Treatment Phase. It is established during the Evaluation Phase and may be revised during the Treatment Phase.

Valid Tests and Instruments means those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

PHASES OF AN APPROVED SIMP

See the Referral and Prior Authorization Requirements section for information about how and when each phase may be prior authorized by the claim manager.

Evaluation Phase

The Evaluation Phase occurs before the Treatment Phase and includes *treatment plan* development and a report. Only one evaluation is allowed per authorization but it can be conducted over 1-2 days. The Evaluation Phase includes all of the following components:

- A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants can perform those medical portions of the pre-treatment evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities (CARF);
- Review of medical records and reports, including diagnostic tests and previous efforts at pain management;
- Assessment of any *important associated conditions* that may hinder recovery e.g. opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease. If such conditions exist, see "Referral and Prior Authorization Requirements" section.
- Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs;
- Psychological and social assessment by a licensed clinical psychologist using *valid tests and instruments;*
- Identification of the worker's family and support resources;
- Identification of the worker's reasons and motivation for participation and improvement;
- Identification of factors that may affect participation in the program;

- Assessment of pain and function using *valid tests and instruments*; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:
  - Activities of Daily Living (ADLs)
  - Range of Motion (ROM)
  - Strength
  - Stamina
  - Capacity for and interest in returning to work
- If the claim manager has assigned a vocational counselor, the SIMP vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity (see "Vocational Services" section);
- A summary report of the evaluation and a preliminary recommended *treatment plan*; if there are any barriers preventing the worker from moving on to the Treatment Phase, the report should explain the circumstances;
- For lumbar surgery candidates, the report should address their expectation and interest in having surgery.

Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts 6-8 hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical or occupational therapists, and may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

- Graded Exercise: Progressive physical activities guided by a physical or occupational therapist that promote flexibility, strength, and endurance to improve function and independence;
- Cognitive Behavioral Therapy: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist, or psychiatric advanced registered nurse practitioner; and
- Coordination of Health Services: Coordination and communication with the attending provider, claim manager, family, employer, and community resources as needed to accomplish the goals set forth in the *treatment plan;*
  - For lumbar surgery candidates, communication and consultation with the spine surgeon is recommended;
  - Education and skill development on the factors that contribute to pain, responses to pain, and effective pain management;
  - For lumbar surgery candidates, this includes provision and review of a patient education aid, provided by the insurer, describing the risks associated with lumbar fusion;
- Tracking of Pain and Function: Individual medical assessment of pain and function levels using valid tests and instruments;
- Ongoing assessment of *important associated conditions*, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment;
- Performance of real or simulated work or daily functional tasks;
- SIMP vocational services may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the Return to Work Action Plan when a vocational referral has been made; and
- A discharge care plan for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the Treatment Phase;
- A report at the conclusion of the Treatment Phase that addresses all the following questions:

- To what extent did the worker meet his or her treatment goals?
- What changes if any, have occurred in the worker's medical and psycho-social conditions, including dependence on opioids and other medications?
- What changes if any, have occurred in the worker's pain level and functional capacity as measured by *valid tests and instruments*?
- What changes if any, have occurred in the worker's ability to manage pain?
- What is the status of the worker's readiness to return to work or daily activities?
- What is the status of progress in achieving the goals listed in the Return to Work Action Plan if applicable?
- How much and what kind of follow up care does the worker need?
- For lumbar surgery candidates, what is the worker's current expectation and interest in having surgery?

Follow up Phase

So long as the claim remains open, a Follow up Phase may occur within 6 months after the Treatment Phase has concluded. This phase isn't a substitute for and cannot serve as an extended Treatment Phase. The goals of the Follow up Phase are to:

- Improve and reinforce the pain management gains made during the Treatment Phase;
- Help the worker integrate the knowledge and skills gained during the Treatment Phase into his or her job, daily activities, and family and community life;
- Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
- Address the goals listed in the Return to Work Action Plan if one was developed.

Site of the Follow up Phase

The activities of the Follow up Phase may occur at the original multidisciplinary clinic (clinic based) or at the worker's home, workplace, or health care provider office (community based). This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow up care at the clinic to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to health care resources.

Face to face vs. Non face to face Services

Follow up services are payable as "face to face" and "non face to face" services. Face to face services are when the provider interacts directly with the worker, the worker's family, employer, or other health care providers. Non face to face services are when the SIMP provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other health care providers for the purpose of coordinating care in the worker's home community. Both are subject to the following limits:

- Face to face services: up to 24 hours are allowed with a maximum of 4 hours per day; and
- Non face to face services: up to 40 hours are allowed.

Reporting Requirements

If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

- The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in his or her community, activity levels, and support systems;

- What was done during the Follow up Phase;
- What resulted from the follow up care; and
- Measures of pain and function using valid tests and instruments.

This summary report must be submitted at the following intervals:

- For non lumbar surgery candidates: at 1 and 3 months;
- For lumbar surgery candidates (regardless of whether they had lumbar surgery after successfully completing SIMP treatment): at 1, 3, *and 6 months*.

The Follow up Phase should include the following kinds of activities according to the worker's identified needs and goals, and may be done either face to face at the clinic or in the community; or as non face to face coordination of community based services:

Evaluation and Assessment Activities during Follow up Phase

- Assess pain and function with valid tests and instruments.
- Evaluate whether the worker is complying with his or her home and work program that was developed at the conclusion of the Treatment Phase.
- Evaluate the worker's dependence, if any, on opioids and other medications for pain.
- Assess important associated conditions and psychological status especially as related to reintegration in the workplace, home and community.
- Assess what kind of support the worker has in the work place, home, and community.
- Assess the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment Activities during Follow up Phase

- Provide brief treatment by a psychologist, physician, nurse, vocational counselor, or physical or occupational therapist.
- Adjust the worker's home and work program for management of chronic pain and reactivation of activities of daily living and work.
- Reinforce goals to improve or maintain progress made during or since the Treatment Phase.
- Teach new techniques or skills that were not part of the original Treatment Phase.
- Address the goals listed in the Return to Work Action Plan if one was developed.

Community Care Coordination during Follow up Phase

- Communicate with the attending provider, surgeon, other providers, the claim manager, insurer assigned vocational counselor, employer, or family and community members to support the worker's continued management of chronic pain.
- Make recommendations for assistance in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support Activities during Follow up Phase

- Contact or visit the worker in his or her community to learn about the worker's current status and needs and help him/her find the needed resources.
- Hold case conferences with the interdisciplinary team of clinicians and/or the worker's attending provider and/or other individuals closely involved with the worker's care and functional recovery.

Special Considerations

When determining what follow up services the worker needs, SIMP providers should consider the following:

- Meeting with the worker, the worker's family, employer, or other health care providers who are treating the worker is subject to the 24 hour limit on face to face services.
- If a SIMP provider plans to travel to the worker's community to deliver face to face services, travel time isn't included in the 24 hour time limit and the trip must be prior authorized for mileage to be reimbursed.
- The required follow up evaluations must be done face to face with the worker and are subject to the 24 hour limit on face to face services.
- When the SIMP provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately.
- Authorized follow up services can be provided, even if the worker has lumbar surgery during the follow up period.
- If a SIMP provider wishes to coordinate the delivery of physical or occupational therapy services in the worker's home community, they should be aware that for workers covered by the State Fund, these therapies are often subject to prior authorization and utilization review. For further information, visit:
- http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/default.asp

POLICY REQUIREMENTS

Requirements the SIMP Provider Must Meet

To provide chronic pain management program services to eligible workers, SIMP service providers must meet all the requirements listed in this section. They must:

- Meet the definition of a Structured Intensive Multidisciplinary Program; and
- Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF). Providers must maintain CARF accreditation and provide the Department of Labor & Industries (L&I) with documentation of satisfactory recertification. A provider's account will be inactivated if CARF accreditation expires. It is the provider's responsibility to notify L&I when an accreditation visit is delayed; and
- Provide the services described in each phase; and
- Communicate with providers who are involved with the worker's care; and
- Ensure care is coordinated with the worker's attending provider; and
- Inform the claim manager whether the worker stops services prematurely, has unexpected adverse occurrences, or doesn't meet the worker requirements; and
- Communicate with the worker during treatment to ensure he or she understands and follows the prescribed treatment; and
- Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed; and
- Coordinate the worker's transition and reintegration back to his or her home, community, and place of employment.

Requirements the Worker Must Meet

An injured worker must make a good faith effort to participate and comply with the *treatment plan* prescribed for him or her by the SIMP provider. To successfully complete a SIMP, the worker must meet all the requirements in this section. The worker must:

- Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of his or her *treatment plan*; and
- Be psychologically stable enough to understand and follow instructions and to put forth an effort to work toward the goals that are part of his or her *treatment plan*; and
- Agree to be evaluated and comply with treatment prescribed for any *important associated conditions* that hinder progress or recovery (e.g. opioid dependence and other substance use disorders, smoking, significant mental health disorders, and other unmanaged chronic disease); and
- Attend each day and each session that is part of his or her *treatment plan*. Sessions may be made up if, in the opinion of the provider, they don't interfere with the worker's progress toward *treatment plan* goals; and
- Cooperate and comply with his or her *treatment plan*; and
- Not pose a threat or risk to himself or herself, to staff, or to others; and
- Review and sign a participation agreement with the provider; and
- Participate with coordination efforts at the end of the Treatment Phase to help him or her transition back to his or her home, community, and workplace.

Referral and Prior Authorization Requirements

1. All SIMP services require:
    - Prior authorization by the claim manager; and
    - A referral from the worker's attending provider.

   An occupational nurse consultant, claim manager, or insurer assigned vocational counselor may recommend a SIMP for the worker, but this cannot substitute for a referral from the attending provider.
2. When the attending provider refers a worker to a chronic pain management program (SIMP), the claim manager may authorize an evaluation if the worker has had unresolved chronic pain for longer than 3 months despite conservative care and has one or more of the following conditions:
    - Is unable to return to work due to the chronic pain;
    - Has returned to work but needs help with chronic pain management;
    - Has significant pain medication dependence, tolerance, abuse, or addiction;
    - Is a lumbar surgery candidate. It is recommended that lumbar surgery candidates be evaluated by a SIMP prior to requesting the surgery.
3. Prior authorization for the Evaluation Phase occurs first and includes only one evaluation. Once authorized, the SIMP provider verifies the worker meets the requirements set forth in the "Requirements the Worker Must Meet" section, and can fully participate in the program. If the worker:
    - Meets the requirements and the SIMP provider recommends the worker move on to the Treatment Phase, the SIMP provider must provide the insurer with a report and treatment plan as described under the Evaluation Phase.
    - Doesn't meet the requirements, the SIMP provider must provide the insurer with a report explaining what requirements aren't met and the goals the worker must meet before he or she can return and participate in the program. If the worker is found to have important associated conditions during the Evaluation Phase that prevent him or her from participating in the Treatment Phase, the SIMP provider must either treat the worker or recommend to the worker's attending provider and the claim manager what type of treatment the worker needs.

4. The Treatment Phase must be prior authorized separately from the Evaluation Phase. Treatment Phase authorization includes authorization for the Follow up Phase.
5. SIMP services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.
6. If a lumbar surgery candidate previously participated in a SIMP as a lumbar surgery candidate but didn't successfully complete treatment, one additional SIMP may be authorized only if:
    - The worker obtains an additional surgical recommendation noting clinical changes one year or more after the date first referred to a SIMP; *or*
    - The reason the worker didn't participate fully or successfully complete a SIMP the first time was because of *important associated conditions* that are now fully resolved.
7. If a lumbar surgery candidate successfully completed a SIMP and didn't have the surgery, and in the future becomes a lumbar surgery candidate again, another SIMP may be authorized, but isn't required.
8. If a worker's treatment is interrupted due to significant family or life circumstances such as a death in the family, the claim manager may authorize resuming or restarting the SIMP if recommended by the SIMP provider.
9. If a SIMP provider plans to travel to the worker's community to deliver face to face services, mileage may be reimbursed, but only if it is prior authorized. Lodging and meals (per diem expenses) aren't reimbursable. Actual travel time isn't included in the 24 hour limit. When requesting prior authorization for mileage, the SIMP provider must explain the reason for the visit and how it will benefit the worker.

VOCATIONAL SERVICES

Vocational Referrals

The claim manager will determine, based on the facts of each case, whether to make a vocational referral prior to authorizing participation in a SIMP. The claim manager may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable. The claim manager won't make a vocational referral when the worker:

- Is working; or
- Is scheduled to return to work; or
- Has been found employable or not likely to benefit from vocational services.

Return to Work Action Plan

A Return to Work Action Plan is required when vocational services are needed in conjunction with SIMP treatment and the claim manager assigns a vocational counselor.

The Return to Work Action Plan provides the focus for vocational services during a worker's participation in a chronic pain management program. The Return to Work Action Plan may be modified or adjusted during the Treatment or Follow up Phase as needed.

At the end of the program, the outcomes listed in the Return to Work Action Plan must be included with the Treatment Phase summary report. If a vocational counselor is assigned, he or she will work with the SIMP vocational counselor to agree upon a Return to Work Action Plan with a return to work goal.

Return to Work Action Plan Roles and Responsibilities

In the development and implementation of the Return to Work Action Plan, the insurer assigned vocational counselor, the SIMP vocational counselor, the attending provider, and the worker are involved. Their specific roles and responsibilities are listed below.

- The SIMP Vocational Counselor:
  - Co-develops the Return to Work Action Plan with the insurer assigned vocational counselor;
  - Presents the Return to Work Action Plan to the claim manager at the completion of the Evaluation Phase if the SIMP recommends the worker move on to the Treatment Phase and needs assistance with a return to work goal;
  - Communicates with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan.
- The insurer assigned vocational counselor:
  - Co-develops the Return to Work Action Plan with the SIMP vocational counselor;
  - Attends the chronic pain management program discharge conference and other conferences as needed either in person or by phone;
  - Negotiates with the attending provider when the initial Return to Work Action Plan isn't approved in order to resolve the attending provider's concerns;
  - Obtains the worker's signature on the Return to Work Action Plan;
  - Communicates with the SIMP vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan;
  - Implements the Return to Work Action Plan following the conclusion of the Treatment Phase.
- The attending provider:
  - Reviews and approves/disapproves the initial Return to Work Action Plan within 15 days of receipt;
  - Reviews and signs the final Return to Work Action Plan at the conclusion of the Treatment Phase within 15 days of receipt;
  - Communicates with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any issues affecting the return to work goal.
- The worker:
  - Will participate in the selection of a return to work goal;
  - Will review and sign the final Return to Work Action Plan;
  - Will cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan. Should the worker fail to be cooperative, the sanctions as set out in RCW 51.32.110 shall be applied.

BILLING RULES

SIMP Fee Schedule

The fee schedule and procedure codes for these phases are listed in the following table. The fee schedule applies to injured workers only in an outpatient program. These outpatient chronic pain management programs must bill using the local codes listed in the following table on a CMS-1500 form.

Description	Local Code	Duration / Limits	Units of Service	Fee Schedule
SIMP Evaluation Services	2010M	1 evaluation per authorization, which may be conducted over 1-2 days	Bill only 1 unit for evaluation even if conducted over 2 days	$1,106.63
SIMP Treatment Services, each 6-8 hour day	2011M	Not to exceed 20 treatment days (6-8 hours per day)	1 day equals 1 unit of service	$708.82 per day
SIMP Follow up Services: Face-to-face services with the worker, the worker's family, employer, or health care providers, either in the clinic or in the worker's community	2014M	Not to exceed 4 hours per day and not to exceed 24 hours total (time must be billed in 1 minute units)	1 minute equals 1 unit of service	$1.48 per minute ($88.80 per hour)
SIMP Follow up Services: Non face-to-face coordination of services with the worker, the worker's family, employer, or health care providers in the worker's community	2015M	Not to exceed 40 hours (time must be billed in 1 minute units)	1 minute equals 1 unit of service	$1.17 per minute ($70.20 per hour)
Mileage for traveling to and from the worker's community	0392R	Mileage requires a separate prior authorization. Travel time isn't included in the 24 hours allotted for face-to-face services.	1 mile equals 1 unit of service	Current Washington State mileage rate

Billing For Partial Days in the Evaluation and Treatment Phases

Clinics can bill only for that percent of an 8 hour day that has been provided, (even if the patient was scheduled for less than 8 hours). Examples:

1. Only one evaluation is payable. If half the evaluation is completed on day one and half is completed on day two, the clinic would bill half of the evaluation rate ($1106.63 x 50% = $553.32) on each day.
2. The worker has an unforeseen emergency and has to leave the clinic after 2 hours (25% of the treatment day). The clinic would bill $708.82 x 25% = $177.21.

MORE INFORMATION

For Crime Victims

- **Phone:** (800) 762-3716 (toll free)
- **Fax:** (360) 902-5333
- Additional information is available at: www.CrimeVictims.Lni.wa.gov

For Self-Insured Claims

Contact the self-insured employer (SIE) or their third party administrator (TPA) to request authorization. For a list of SIE/TPAs, go to:
http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp

Appendices

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APPENDIX A
ENDOSCOPY FAMILIES

The descriptions and complete coding information may be found in the current CPT® or HCPCS Manuals.

Base	Family
29805	29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827 and 29828
29830	29834, 29835, 29836, 29837 and 29838
29840	29843, 29844, 29845, 29846 and 29847
29860	29861, 29862, 29863, 29915, 29915 and 29916
29870	29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886 and 29887
31505	31510, 31511, 31512 and 31513
31525	31527, 31528, 31529, 31530, 31535, 31540, 31560 and 31570
31526	31531, 31536, 31541, 31545, 31546, 31561 and 31571
31575	31576, 31577, 31578 and 31579
31622	31623, 31624, 31625, 31628, 31629, 31630, 31631, 31634, 31635, 31636, 31638, 31640, 31641, and 31645
43200	43201, 43202, 43204, 43205, 43215, 43216, 43217, 43219, 43220, 43226, 43227 and 43228
43235	43231, 43232, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43256, 43257, 43258 and 43259
43260	43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, and 43272
44360	44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372 and 44373
44376	44377, 44378 and 44379
44388	44389, 44390, 44391, 44392, 44393, 44394 and 44397
45300	45303, 45305, 45307, 45308, 45309, 45315, 45317, 45320, 45321 and 45327
45330	45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340 and 45345
45378	45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391 and 45392
46600	46604, 46606, 46608, 46610, 46611, 46612, 46614 and 46615
47552	47553, 47554, 47555 and 47556
49320	38570, 49321, 49322, 49323, 49324, 49325, 58541, 58550, 58660, 58661, 58662, 58670, 58671, 58672 and 58673
50551	50555, 50557 and 50561
50570	50572, 50574, 50575, 50576 and 50580
50951	50953, 50955, 50957 and 50961
50970	50974 and 50976
52000	52001, 52005, 52007, 52010, 52204, 52214, 52224, 52234, 52235, 52240, 52250, 52260, 52265, 52270, 52275, 52276, 52277, 52281, 52282, 52283, 52285, 52290, 52300, 52301, 52305, 52310, 52315, 52317,,52318, 52320, 52325, 52327, 52330, 52332, 52334, 52341, 52342, 52343, 52344, 52400 and 52402
52351	52345, 52346, 52352, 52353, 52354 and 52355
57452	57454,57455, 57456, 57460 and 57461
58555	58558, 58559, 58560, 58561, 58562, 58563 and 58565

APPENDIX B
BUNDLED SERVICES

The descriptions and complete coding information may be found in the current CPT® or HCPCS Manuals.

Bundled CPT® Code
15850
20930
20936
22841
90885
90887
90889
92352
92353
92354
92355
92358
92371

Bundled CPT® Code
92531
92532
92533
92534
92605
92606
92613
92615
92617
93770
94150
94760
94761

Bundled CPT® Code
96545
97010
97605
97606
99000
99001
99002
99024
99051
99056
99058
99078
99090

Bundled CPT® Code
99091
99100
99116
99135
99140
99144
99145
99173
99358
99359
99374
99377
99379

Bundled HCPCS Codes	
Code	Abbreviated Description
A9900	Supply/accessory/service
D1310	Nutri counsel-control caries
D1320	Tobacco counseling
D1330	Oral hygiene instruction
D3910	Isolation- tooth w rubb dam
D9211	Regional block anesthesia
D9212	Trigeminal block anesthesia
D9215	Local anesthesia
G0008	Admin influenza virus vac
G0009	Admin pneumococcal vaccine
G0010	Admin hepatitis b vaccine
G0117	Glaucoma scrn hgh risk direc
G0118	Glaucoma scrn hgh risk direc
G9141	Admin Influenza vaccine
Q3031	Collagen Skin Test
R0076	Transport portable EKG
V5010	Assessment for hearing aid
V5011	Fit/orientation/check of hearing aid
V5020	Conformity evaluation

APPENDIX C
BUNDLED SUPPLIES

Don't rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT® or HCPCS book for complete coding information.

Items with an asterisk (*) are used as orthotics/prosthetics and may be paid separately for **permanent** conditions if they are provided in the physician's office. These items aren't considered prosthetics if the condition is acute or temporary.

For example, Foley catheters and accessories for permanent incontinence or ostomy supplies for permanent conditions may be paid separately when provided in the physician's office. The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction would not be paid separately because it is treating a temporary problem. If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, then the catheter would be considered a prosthetic/orthotic and would be paid separately.

Surgical dressings and other items dispensed for home use are separately payable when billed with local modifier –1S.

Bundled CPT® Code
99070
99071

Bundled HCPCS Codes	
Code	Abbreviated Description
A0380	Basic life support mileage
A0382	Basic support routine suppls
A0384	Bls defibrillation supplies
A0390	Advanced life support mileag
A0392	Als defibrillation supplies
A0394	Als IV drug therapy supplies
A0396	Als esophageal intub suppls
A0398	Als routine disposble suppls
A0420	Ambulance waiting 1/2 hr
A0422	Ambulance 02 life sustaining
A0424	Extra ambulance attendant
A4206	1 CC sterile syringe & needle
A4207	2 CC sterile syringe & needle
A4208	3 CC sterile syringe & needle
A4209	5+ CC sterile syringe & needle
A4211	Supp for self-adm injections
A4212	Non coring needle or stylet
A4213	20+ CC syringe only

Bundled HCPCS Codes	
Code	Abbreviated Description
A4215	Sterile needle
A4216	Sterile water/saline, 10 ml
A4217	Sterile water/saline, 500 ml
A4218	Sterile saline or water
A4244	Alcohol or peroxide per pint
A4245	Alcohol wipes per box
A4246	Betadine/phisohex solution
A4247	Betadine/iodine swabs/wipes
A4248	Chlorhexidine antisept
A4250	Urine reagent strips/tablets
A4252	Blood ketone test or strip
A4253	Blood glucose/reagent strips
A4256	Calibrator solution/chips
A4257	Replace Lensshield Cartridge
A4258	Lancet device each
A4259	Lancets per box
A4262	Temporary tear duct plug
A4263	Permanent tear duct plug

Bundled HCPCS Codes	
Code	Abbreviated Description
A4265	Paraffin
A4270	Disposable endoscope sheath
A4300	Cath impl vasc access portal
A4301	Implantable access syst perc
A4305	Drug delivery system >=50 ML
A4306	Drug delivery system <=5 ML
A4310	Insert tray w/o bag/cath
A4311	Catheter w/o bag 2-way latex
A4312	Cath w/o bag 2-way silicone
A4313	Catheter w/bag 3-way
A4314	Cath w/drainage 2-way latex
A4315	Cath w/drainage 2-way silcne
A4316	Cath w/drainage 3-way
A4320	Irrigation tray
A4321	Cath therapeutic irrig agent
A4322	Irrigation syringe
A4326*	Male external catheter
A4327*	Fem urinary collect dev cup
A4328*	Fem urinary collect pouch
A4330	Stool collection pouch
A4331	Extension drainage tubing
A4332	Lubricant for cath insertion
A4333	Urinary cath anchor device
A4334	Urinary cath leg strap
A4335*	Incontinence supply
A4336	Urethral insert
A4338*	Indwelling catheter latex
A4340*	Indwelling catheter special
A4344*	Cath indw foley 2 way silicn
A4346*	Cath indw foley 3 way
A4349	Disposable male external cat
A4351	Straight tip urine catheter
A4352	Coude tip urinary catheter
A4353	Intermittent urinary cath
A4354	Cath insertion tray w/bag
A4355	Bladder irrigation tubing
A4356*	Ext ureth clmp or compr dvc
A4357*	Bedside drainage bag
A4358*	Urinary leg bag
A4360	Disposable ext urethral dev
A4361*	Ostomy face plate
A4362*	Solid skin barrier

Bundled HCPCS Codes	
Code	Abbreviated Description
A4363	Ostomy clamp, replacement
A4364*	Ostomy/cath adhesive
A4366*	Ostomy vent
A4367*	Ostomy belt
A4368*	Ostomy filter
A4369*	Skin barrier liquid per oz
A4371*	Skin barrier powder per oz
A4372*	Skin barrier solid 4x4 equiv
A4373*	Skin barrier with flange
A4375*	Drainable plastic pch w fcpl
A4376*	Drainable rubber pch w fcplt
A4377*	Drainable plstic pch w/o fp
A4378*	Drainable rubber pch w/o fp
A4379*	Urinary plastic pouch w fcpl
A4380*	Urinary rubber pouch w fcplt
A4381*	Urinary plastic pouch w/o fp
A4382*	Urinary hvy plstc pch w/o fp
A4383*	Urinary rubber pouch w/o fp
A4384*	Ostomy faceplt/silicone ring
A4385*	Ost skn barrier sld ext wear
A4387*	Ost clsd pouch w att st barr
A4388*	Drainable pch w ex wear barr
A4389*	Drainable pch w st wear barr
A4390*	Drainable pch ex wear convex
A4391*	Urinary pouch w ex wear barr
A4392*	Urinary pouch w st wear barr
A4393*	Urine pch w ex wear bar conv
A4394*	Ostomy pouch liq deodorant
A4395*	Ostomy pouch solid deodorant
A4396	Peristomal hernia supprt blt
A4397	Irrigation supply sleeve
A4398*	Ostomy irrigation bag
A4399*	Ostomy irrig cone/cath w brs
A4400*	Ostomy irrigation set
A4402*	Lubricant per ounce
A4404*	Ostomy ring each
A4405*	Nonpectin based ostomy paste
A4406*	Pectin based ostomy paste
A4407*	Ext wear ost skn barr <=4sq"
A4408*	Ext wear ost skn barr >4sq"
A4409*	Ost skn barr w flng <=4 sq"
A4410*	Ost skn barr w flng >4sq"

Bundled HCPCS Codes	
Code	Abbreviated Description
A4411	Ost skn barr extnd =4sq
A4412	Ost pouch drain high output
A4413*	2 pc drainable ost pouch
A4414*	Ostomy sknbarr w flng <=4sq"
A4415*	Ostomy skn barr w flng >4sq"
A4416*	Ost pch clsd w barrier/filtr
A4417*	Ost pch w bar/bltinconv/fltr
A4418*	Ost pch clsd w/o bar w filtr
A4419*	Ost pch for bar w flange/flt
A4420*	Ost pch clsd for bar w lk fl
A4421*	Ostomy supply misc
A4422*	Ost pouch absorbent material
A4423*	Ost pch for bar w lk fl/fltr
A4424*	Ost pch drain w bar & filter
A4425*	Ost pch drain for barrier fl
A4426*	Ost pch drain 2 piece system
A4427*	Ost pch drain/barr lk flng/f
A4428*	Urine ost pouch w faucet/tap
A4429*	Urine ost pouch w bltinconv
A4430*	Ost urine pch w b/bltin conv
A4431*	Ost pch urine w barrier/tapv
A4432*	Os pch urine w bar/fange/tap
A4433*	Urine ost pch bar w lock fln
A4434*	Ost pch urine w lock flng/ft
A4450	Non-waterproof tape
A4452	Waterproof tape
A4455	Adhesive remover per ounce
A4456	Adhesive remover, wipes
A4458	Reusable enema bag
A4461	Surgicl dress hold non-reuse
A4463	Surgical dress holder reuse
A4465	Non-elastic extremity binder
A4466	Elastic garment/covering
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4520	Incontinence garment anytype
A4550	Surgical trays
A4554	Disposable underpads
A4556	Electrodes, pair
A4557	Lead wires, pair
A4558	Conductive paste or gel
A4559	Coupling gel or paste

Bundled HCPCS Codes	
Code	Abbreviated Description
A4649	Surgical supplies
A4670	Auto blood pressure monitor
A4930	Sterile, gloves per pair
A5051*	Pouch clsd w barr attached
A5052*	Clsd ostomy pouch w/o barr
A5053*	Clsd ostomy pouch faceplate
A5054*	Clsd ostomy pouch w/flange
A5055*	Stoma cap
A5061*	Pouch drainable w barrier at
A5062*	Drnble ostomy pouch w/o barr
A5063*	Drain ostomy pouch w/flange
A5071*	Urinary pouch w/barrier
A5072*	Urinary pouch w/o barrier
A5073*	Urinary pouch on barr w/flng
A5081*	Continent stoma plug
A5082*	Continent stoma catheter
A5083*	Stoma absorptive cover
A5093*	Ostomy accessory convex inse
A5102*	Bedside drain btl w/wo tube
A5105*	Urinary suspensory
A5112*	Urinary leg bag
A5113*	Latex leg strap
A5114*	Foam/fabric leg strap
A5120	Skin barrier, wipe or swab
A5121*	Solid skin barrier 6x6
A5122*	Solid skin barrier 8x8
A5126*	Disk/foam pad +or- adhesive
A5131*	Appliance cleaner
A6011	Collagen gel/paste wound fil
A6010	Collagen based wound filler
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch each
A6196	Alginate dressing <=16 sq in
A6197	Alginate drsg >16 <=48 sq in
A6198	alginate dressing > 48 sq in
A6199	Alginate drsg wound filler
A6203	Composite drsg <= 16 sq in
A6204	Composite drsg >16<=48 sq in

Bundled HCPCS Codes	
Code	Abbreviated Description
A6205	Composite drsg > 48 sq in
A6206	Contact layer <= 16 sq in
A6207	Contact layer >16<= 48 sq in
A6208	Contact layer > 48 sq in
A6209	Foam drsg <=16 sq in w/o bdr
A6210	Foam drg >16<=48 sq in w/o b
A6211	Foam drg > 48 sq in w/o brdr
A6212	Foam drg <=16 sq in w/border
A6213	Foam drg >16<=48 sq in w/bdr
A6214	Foam drg > 48 sq in w/border
A6215	Foam dressing wound filler
A6216	Non-sterile gauze<=16 sq in
A6217	Non-sterile gauze>16<=48 sq
A6218	Non-sterile gauze > 48 sq in
A6219	Gauze <= 16 sq in w/border
A6220	Gauze >16 <=48 sq in w/bordr
A6221	Gauze > 48 sq in w/border
A6222	Gauze <=16 in no w/sal w/o b
A6223	Gauze >16<=48 no w/sal w/o b
A6224	Gauze > 48 in no w/sal w/o b
A6228	Gauze <= 16 sq in water/sal
A6229	Gauze >16<=48 sq in watr/sal
A6230	Gauze > 48 sq in water/salne
A6231	Hydrogel dsg<=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
A6234	Hydrocolld drg <=16 w/o bdr
A6235	Hydrocolld drg >16<=48 w/o b
A6236	Hydrocolld drg > 48 in w/o b
A6237	Hydrocolld drg <=16 in w/bdr
A6238	Hydrocolld drg >16<=48 w/bdr
A6239	Hydrocolld drg > 48 in w/bdr
A6240	Hydrocolld drg filler paste
A6241	Hydrocolloid drg filler dry
A6242	Hydrogel drg <=16 in w/o bdr
A6243	Hydrogel drg >16<=48 w/o bdr
A6244	Hydrogel drg >48 in w/o bdr
A6245	Hydrogel drg <= 16 in w/bdr
A6246	Hydrogel drg >16<=48 in w/b
A6247	Hydrogel drg > 48 sq in w/b
A6248	Hydrogel drsg gel filler
A6250	Skin seal protect moisturizr

Bundled HCPCS Codes	
Code	Abbreviated Description
A6251	Absorpt drg <=16 sq in w/o b
A6252	Absorpt drg >16 <=48 w/o bdr
A6253	Absorpt drg > 48 sq in w/o b
A6254	Absorpt drg <=16 sq in w/bdr
A6255	Absorpt drg >16<=48 in w/bdr
A6256	Absorpt drg > 48 sq in w/bdr
A6257	Transparent film <= 16 sq in
A6258	Transparent film >16<=48 in
A6259	Transparent film > 48 sq in
A6260	Wound cleanser any type/size
A6261	Wound filler gel/paste /oz
A6262	Wound filler dry form / gram
A6266	Impreg gauze no h20/sal/yard
A6402	Sterile gauze <= 16 sq in
A6403	Sterile gauze>16 <= 48 sq in
A6404	Sterile gauze > 48 sq in
A6407	Packing strips, non-impreg
A6410	Sterile eye pad
A6411	Non-sterile eye pad
A6412	Occlusive eye patch
A6413	Adhesive bandage, first-aid
A6441	Pad band w>=3” <5”/yd
A6442	Conform band n/s w<3”/yd
A6443	Conform band n/s w>=3”<5”/yd
A6444	Conform band n/s w>=5”/yd
A6445	Conform band s w <3”/yd
A6446	Conform band s w>=3” <5”/yd
A6447	Conform band s w >=5”/yd
A6448	Lt compres band <3”/yd
A6449	Lt compres band >=3” <5”/yd
A6450	Lt compres band >=5”/yd
A6451	Mod compr band w>=3”<5”/yd
A6452	High compr band w>=3”<5”yd
A6453	Self-adher band w <3”/yd
A6454	Self-adher band w>=3” <5”/yd
A6455	Self-adher band >=5”/yd
A6456	Zinc paste band w >=3”<5”/yd
A6457	Tubular dressing
A9150	Nonprescription drug
A9273	Hot/cold H20bot/cap/col/wrap
A9900	Supply/accessory/service
J3535	Metered dose inhaler drug

Bundled HCPCS Codes	
Code	Abbreviated Description
J7599	Immunosuppressive drug, noc
J7699	Noninhalation drug for DME
J7799	Non-inhalation drug for DME
J8498	Antiemetic drug, rctal/supp, nos
J8499	Oral prescript drug nonchemo
J8597	Antiemetic drug, oral, nos
J8999	Oral prescription drug chemo
L8699	Prosthetic implant NOS
T4521	Adult size brief/diaper sm
T4522	Adult size brief/diaper med
T4523	Adult size brief/diaper lg
T4524	Adult size brief/diaper xl
T4525	Adult size pull-on sm

Bundled HCPCS Codes	
Code	Abbreviated Description
T4526	Adult size pull-on med
T4527	Adult size pull-on lg
T4528	Adult size pull-on xl
T4533	Youth size brief/diaper
T4534	Youth size pull-on
T4535	Disposable liner/shield/pad
T4536	Reusable pull-on any size
T4537	Reusable underpad bed size
T4539	Reuse diaper/brief any size
T4540	Reusable underpad chair size
T4541	Large disposable underpad
T4542	Small disposable underpad

APPENDIX D
NON-COVERED CODES

The descriptions and complete coding information may be found in the current CPT® or HCPCS Manuals.

Non-Covered CPT® Code
00326
00529
00561
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered HCPCS Codes	
Code	Brief Description
A0432	PI volunteer ambulance co
A0888	Noncovered ambulance mileage
A0998	Ambulance resp/treatment
A4261	Cervical cap contraceptive
A4264	Intratubal occlusion device
A4266	Diaphragm
A4267	Male condom
A4268	Female condom
A4269	Spermicide
A4281	Replacement breast pump tube
A4282	Replacement breast pump adpt
A4283	Replacement breast pump cap
A4284	Replcmnt breast pump shield
A4285	Replcmnt breast pump bottle
A4286	Replcmnt breast pump lok ring
A4561	Pessary rubber, any type
A4562	Pessary, non rubber, any type
A4570	Splint
A4580	Cast supplies (plaster)
A4590	Special casting material
A4595	TENS suppl 2 lead per month
A4630	Repl bat t.e.n.s. own by pt
A4633	Uvl replacement bulb
A4634	Replacement bulb th lightbox
A4638	Repl batt pulse gen sys
A4639	Infrared ht sys replcmnt pad
A4931	Reusable oral thermometer
A4932	Reusable rectal thermometer
A7025	Replace chest compress vest
A7026	Replace chst cmprss sys hose
A7044	PAP oral interface
A9152	Single vitamin nos
A9153	Multi-vitamin nos
A9180	Lice treatment, topical
A9270	Non-covered item or service
A9282	Wig any type
A9300	Exercise equipment
A9582	Iodine I-123 iobenguane
A9604	Sm 153 lexidronam
B4103	EF ped fluid and electrolyte
B4158	EF ped complete intact nut
B4159	EF ped complete soy based

Non-Covered HCPCS Codes	
Code	Brief Description
B4160	EF ped caloric dense>/=0.7kc
B4161	EF ped hydrolyzed/amino acid
B4162	EF ped specmetabolic inherit
C1716	Brachytx, non-str, Gold-198
C1717	Brachytx, non-str,HDR Ir-192
C1719	Brachytx, NS, Non-HDRIr-192
C1820	Generator neuro rechg bat sy
C1821	Interspinous implant
C2614	Probe, perc lumb disc
C2634	Brachytx source, HA, I-125
C2635	Brachytx source, HA, P-103
C2636	Brachytx linear source, P-103
C2637	Brachytx, Ytterbium-169
C2638	Brachytx, stranded, I-125
C2639	Brachytx, non-stranded,I-125
C2640	Brachytx, stranded, P-103
C2641	Brachytx, non-stranded,P-103
C2642	Brachytx, stranded, C-131
C2643	Brachytx, non-stranded,C-131
C8921	Comp transtho echo w/contr
C8922	Limit transtho echo w/contr
C8926	Cong TEE w/contr, int/rept
C9257	Bevacizumab injection
C9270	Gammaplex IVIG
C9273	Sipuleucel-T, per infusion
C9276	Cabazitaxel injection
C9277	Lumizyme, 1 mg
C9364	Porcine implant, Permacol
C9725	Place endorectal app
C9726	Rxt breast appl place/remov
C9728	Place device/marker, non pro
C9800	Dermal filler inj px/suppl
C9899	Inpt implant pros dev,no cov
D0120	Periodic oral evaluation
D0145	Oral evaluation, pt < 3yrs
D0180	Comp periodontal evaluation
D0310	Dental saliography
D0415	Collection of microorganisms
D0416	Viral culture
D0417	Collect & prep saliva sample
D0418	Analysis of saliva sample
D0421	Gen tst suscept oral disease

Non-Covered HCPCS Codes	
Code	Brief Description
D0425	Caries susceptibility test
D0431	Diag tst detect mucos abnorm
D0472	Gross exam, prep & report
D0473	Micro exam, prep & report
D0474	Micro w exam of surg margins
D0475	Decalcification procedure
D0476	Spec stains for microorganis
D0477	Spec stains not for microorg
D0478	Immunohistochemical stains
D0479	Tissue in-situ hybridization
D0480	Cytopath smear prep & report
D0481	Electron microscopy diagnost
D0482	Direct immunofluorescence
D0483	Indirect immunofluorescence
D0484	Consult slides prep elsewher
D0485	Consult inc prep of slides
D0486	Accession of brush biopsy
D1120	Dental prophylaxis child
D1203	Topical app fluoride child
D1204	Topical app fluoride adult
D1206	Topical fluoride varnish
D1351	Dental sealant per tooth
D2410	Dental gold foil one surface
D2420	Dental gold foil two surface
D2430	Dental gold foil three surfa
D2510	Dental inlay metalic 1 surf
D2520	Dental inlay metallic 2 surf
D2530	Dental inlay metl 3/more sur
D2542	Dental onlay metallic 2 surf
D2543	Dental onlay metallic 3 surf
D2544	Dental onlay metl 4/more sur
D2610	Inlay porcelain/ceramic 1 su
D2620	Inlay porcelain/ceramic 2 su
D2630	Dental onlay porc 3/more sur
D2642	Dental onlay porcelin 2 surf
D2643	Dental onlay porcelin 3 surf
D2644	Dental onlay porc 4/more sur
D2650	Inlay composite/resin one su
D2651	Inlay composite/resin two su
D2652	Dental inlay resin 3/mre sur
D2662	Dental onlay resin 2 surface
D2663	Dental onlay resin 3 surface

Non-Covered HCPCS Codes	
Code	Brief Description
D2664	Dental onlay resin 4/mre sur
D1320	Tobacco counseling
D3222	Part pulp for apexogenesis
D4241	Gngvl flap w rootplan 1-3 th
D4261	Osseous surgl-3teethperquad
D3230	Pulpal therapy anterior prim
D3240	Pulpal therapy posterior pri
D4341	Periodontal scaling & root
D4342	Periodontal scaling 1-3teeth
D4355	Full mouth debridement
D4381	Localized delivery antimicro
D4910	Periodontal maint procedures
D5952	Pediatric speech aid
D5983	Radiation applicator
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride applicator
D5991	Topical medicament carrier
D6548	Porcelain/ceramic retainer
D6600	Porcelain/ceramic inlay 2srf
D6601	Porc/ceram inlay >= 3 surfac
D6602	Cst hgh nble mtl inlay 2 srf
D6603	Cst hgh nble mtl inlay >=3sr
D6604	Cst bse mtl inlay 2 surfaces
D6605	Cst bse mtl inlay >= 3 surfa
D6606	Cast noble metal inlay 2 sur
D6607	Cst noble mtl inlay >=3 surf
D6608	Onlay porc/crmc 2 surfaces
D6609	Onlay porc/crmc >=3 surfaces
D6610	Onlay cst hgh nbl mtl 2 srfc
D6611	Onlay cst hgh nbl mtl >=3srf
D6612	Onlay cst base mtl 2 surface
D6613	Onlay cst base mtl >=3 surfa
D6614	Onlay cst nbl mtl 2 surfaces
D6615	Onlay cst nbl mtl >=3 surfac
D6624	Inlay titanium
D6634	Onlay titanium
D6985	Pediatric partial denture fx
D7280	Exposure impact tooth orthod
D7282	Mobilize erupted/malpos toot
D7283	Place device impacted tooth
D7411	Excision benign lesion>1.25c

Non-Covered HCPCS Codes	
Code	Brief Description
D7412	Excision benign lesion compl
D7413	Excision malig lesion<=1.25c
D7414	Excision malig lesion>1.25cm
D7415	Excision malig les complicat
D7472	Removal of torus palatinus
D7473	Remove torus mandibularis
D7485	Surg reduct osseoustuberosit
D7963	Frenuloplasty
D7972	Surg redct fibrous tuberosit
D9999	Adjunctive procedure
D7440	Malig tumor exc to 1.25 cm
D7441	Malig tumor > 1.25 cm
D7490	Maxilla or mandible resectio
D7980	Sialolithotomy
D7981	Excision of salivary gland
D8010	Limited dental tx primary
D8020	Limited dental tx transition
D8050	Intercep dental tx primary
D8060	Intercep dental tx transitn
D8070	Compre dental tx transition
D9970	Enamel microabrasion
D9972	Extrnl bleaching per arch
E0190	Positioning cushion
E0200	Heat lamp without stand
E0202	Phototherapy light w/ photom
E0203	Therapeutic lightbox tabletp
E0205	Heat lamp with stand
E0210	Electric heat pad standard
E0215	Electric heat pad moist
E0217	Water circ heat pad w pump
E0218	Water circ cold pad w pump
E0220	Hot water bottle
E0221	Infrared heating pad system
E0225	Hydrocollator unit
E0235	Paraffin bath unit, portable
E0236	Pump for water circulating p
E0238	Heat pad non-electric moist
E0239	Hydrocollator unit portable
E0249	Pad water circulating heat u
E0300	Enclosed ped crib hosp grade
E0328	Ped hospital bed, manual
E0329	Ped hospital bed semi/elect
E0425	Gas system stationary compre

Non-Covered HCPCS Codes	
Code	Brief Description
E0430	Oxygen system gas portable
E0435	Oxygen system liquid portabl
E0440	Oxygen system liquid station
E0487	Electronic spirometer
E0500	Ippb all types
E0602	Breast pump
E0603	Electric breast pump
E0604	Hosp grade elec breast pump
E0618	Apnea monitor
E0619	Apnea monitor w recorder
E0691	Uvl pnl 2 sq ft or less
E0692	Uvl sys panel 4 ft
E0693	Uvl sys panel 6 ft
E0694	Uvl md cabinet sys 6 ft
E0720	TENS two lead
E0730	Tens four lead
E0731	Conductive garment for tens
E0740	Incontinence treatment systm
E0744	Neuromuscular stim for scoli
E0755	Electronic salivary reflex s
E0762	Trans elec jt stim dev sys
E0765	Nerve stimulator for tx n&v
E0769	Electric wound treatment dev
E0941	Gravity assisted traction de
E1011	Ped wc modify width adjustm
E1014	Reclining back add ped w/c
E1037	Transport chair, ped size
E1229	Pediatric wheelchair NOS
E1231	Rigid ped w/c tilt-in-space
E1232	Folding ped wc tilt-in-space
E1233	Rig ped wc tltnspc w/o seat
E1234	Fld ped wc tltnspc w/o seat
E1235	Rigid ped wc adjustable
E1236	Folding ped wc adjustable
E1237	Rgd ped wc adjstabl w/o seat
E1238	Fld ped wc adjstabl w/o seat
E1239	Ped power wheelchair NOS
E1300	Whirlpool, protable
E1310	Whirlpool, non-portable
E2120	Pulse gen sys tx endolymp fl
E2291	Planar back for ped size wc
E2292	Planar seat for ped size wc

Non-Covered HCPCS Codes	
Code	Brief Description
E2293	Contour back for ped size wc
E2294	Contour seat for ped size wc
E2295	Ped dynamic seating frame
E8000	Posterior gait trainer
E8001	Upright gait trainer
E8002	Anterior gait trainer
G0128	CORF skilled nursing service
G0129	Occ therapy, partial hosp
G0155	Svcs of clin soc wkr under hm hlth,
G0157	HHC PT assistant ea 15
G0158	HHC OT assistant ea 15
G0159	HHC PT maint ea 15 min
G0160	HHC Occup Therapy ea 15
G0161	HHC SLP ea 15 min
G0163	HHC LPN/RN obs/asses ea 15
G0164	HHC lis nurse train ea 15
G0176	OPPS/PHP;activity therapy
G0179	MD recert HHA patient
G0180	MD certification HHA patient
G0181	Home health care supervision
G0182	Hospice care supervision
G0219	PET img wholbod melano non-co
G0235	PET not otherwise specified
G0245	Initial foot exam pt lops
G0246	Followup eval of foot pt lop
G0247	Routine footcare pt w lops
G0251	Stereotactic radiosurgery
G0252	PET imaging
G0255	Current percep threshold tst
G0268	Removal of impacted wax md
G0270	MNT subs tx for change dx
G0271	Group MNT 2 or more 30 mins
G0290	Drug-eluting stents, single
G0291	Drug-eluting stents,each add
G0293	Non-cov surg proc,clin trial
G0294	Non-cov proc, clinical trial
G0295	Electromagnetic therapy onc
G0328	Fecal blood screening immunoassay.
G0329	Electromagnetic tx for ulcers
G0333	Dispense fee initial 30 day
G0339	Robot lin-radsurg com, first
G0340	Robt lin-radsurg fractx 2-5

Non-Covered HCPCS Codes	
Code	Brief Description
G0341	Percutaneous Islet cell trans
G0342	Laparoscopy Islet cell trans
G0343	Laparotomy Islet cell trans
G0372	MD service required for PMD
G0377	Administra Part D vaccine
G0396	Alcohol/subs interv 15-30mn
G0397	Alcohol/subs interv >30 min
G0402	Initial preventive exam
G0403	EKG for initial prevent exam
G0404	EKG tracing for initial prev
G0405	EKG interpret & report preve
G0406	Telhealth inpt consult 15min
G0407	Telheath inpt consult 25min
G0408	Telhealth inpt consult 35min
G0409	CORF related serv 15 mins ea
G0416	Sat biopsy prostate 1-20 spc
G0417	Sat biopsy prostate 21-40
G0418	Sat biopsy prostate 41-60
G0419	Sat biopsy prostate: >60
G0430	Drug screen multi class
G0431	Drug screen single class
G0428	Collagen Meniscus Implant
G0429	Dermal filler injection(s)
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel>10min
G0438	PPPS, initial visit
G0439	PPPS, subseq visit
G0440	Skin/dermal subs init 25or<
G0441	Skin/dermal subs each additi
G3001	Admin + supply, tositumomab
G8006	AMI pt recd aspirin at arriv
G8007	AMI pt did not receiv aspiri
G8008	AMI pt ineligible for aspiri
G8009	AMI pt recd Bblock at arr
G8010	AMI pt did not rec bblock
G8011	AMI pt inelig Bbloc at arriv
G8012	Pneum pt recv antibiotic 4 h
G8013	Pneum pt w/o antibiotic 4 hr
G8014	Pneum pt not elig antibiotic
G8015	Diabetic pt w/ HBA1c>9%
G8016	Diabetic pt w/ HBA1c<or=9%
G8017	DM pt inelig for HBA1c measu

Non-Covered HCPCS Codes	
Code	Brief Description
G8018	Care not provided for HbA1c
G8019	Diabetic pt w/LDL>= 100mg/dl
G8020	Diab pt w/LDL< 100mg/dl
G8021	Diab pt inelig for LDL meas
G8022	Care not provided for LDL
G8023	DM pt w BP>=140/80
G8024	Diabetic pt wBP<140/80
G8025	Diabetic pt inelig for BP me
G8026	Diabet pt w no care re BP me
G8027	HF p w/LVSD on ACE-I/ARB
G8028	HF pt w/LVSD not on ACE-I/AR
G8029	HF pt not elig for ACE-I/ARB
G8030	HF pt w/LVSD on Bblocker
G8031	HF pt w/LVSD not on Bblocker
G8032	HF pt not elig for Bblocker
G8033	PMI-CAD pt on Bblocker
G8034	PMI-CAD pt not on Bblocker
G8035	PMI-CAD pt inelig Bblocker
G8036	AMI-CAD pt doc on antiplatel
G8037	AMI-CAD pt not docu on antip
G8038	AMI-CAD inelig antiplate mea
G8039	CAD pt w/LDL>100mg/dl
G8040	CAD pt w/LDL<or=100mg/dl
G8041	CAD pt not eligible for LDL
G8051	Osteoporosis assess
G8052	Osteopor pt not assess
G8053	Pt inelig for osteopor meas
G8054	Falls assess not docum 12 mo
G8055	Falls assess w/ 12 mon
G8056	Not elig for falls assessmen
G8057	Hearing assess receive
G8058	Pt w/o hearing assess
G8059	Pt inelig for hearing assess
G8060	Urinary incont pt assess
G8061	Pt not assess for urinary in
G8062	Pt not elig for urinary inco
G8075	ESRD pt w/ dialy of URR>=65%
G8076	ESRD pt w/ dialy of URR<65%
G8077	ESRD pt not elig for URR/KtV
G8078	ESRD pt w/Hct>or=33
G8079	ESRD pt w/Hct<33
G8080	ESRD pt inelig for HCT/Hgb

Non-Covered HCPCS Codes	
Code	Brief Description
G8081	ESRD pt w/ auto AV fistula
G8082	ESRD pt w other fistula
G8093	COPD pt rec smoking cessat
G8094	COPD pt w/o smoke cessat int
G8099	Osteopo pt given Ca+VitD sup
G8100	Osteop pt inelig for Ca+VitD
G8103	New dx osteo pt w/antiresorp
G8104	Osteo pt inelig for antireso
G8106	Bone dens meas test perf
G8107	Bone dens meas test inelig
G8108	Pt receiv influenza vacc
G8109	Pt w/o influenza vacc
G8110	Pt inelig for influenza vacc
G8111	Pt receiv mammogram
G8112	Pt not doc mammogram
G8113	Pt ineligible mammography
G8114	Care not provided for mamogr
G8115	Pt receiv pneumo vacc
G8116	Pt did not rec pneumo vacc
G8117	Pt was inelig for pneumo vac
G8126	Pt treat w/antidepress12wks
G8127	Pt not treat w/antidepres12w
G8128	Pt inelig for antidepres med
G8129	Pt treat w/antidepres for 6m
G8130	Pt not treat w/antidepres 6m
G8131	Pt inelig for antidepres med
G8152	Pt w/AB 1 hr prior to incisi
G8153	Pt not doc for AB 1 hr prior
G8154	Pt ineligi for AB therapy
G8155	Pt recd thromboemb prophylax
G8156	Pt did not rec thromboembo
G8157	Pt ineligi for thrombolism
G8159	Pt w/CABG w/o IMA
G8162	Iso CABG pt w/o preop Bblock
G8164	Iso CABG pt w/prolng intub
G8165	Iso CABG pt w/o prolng intub
G8166	Iso CABG req surg rexpo
G8167	Iso CABG w/o surg explo
G8170	CEA/ext bypass pt on aspirin
G8171	Pt w/carot endarct/ext bypas
G8172	CEA/ext bypass pt not on asp
G8182	CAD pt care not prov LDL

Non-Covered HCPCS Codes	
Code	Brief Description
G8183	HF/atrial fib pt on warfarin
G8184	HF/atrial fib pt inelig warf
G8185	Osteoarth pt w/ assess pain
G8186	Osteoarth pt inelig assess
G8193	Antibio not doc prior surg
G8196	Antibio not docum prior surg
G8200	Cefazolin not docum prophy
G8204	MD not doc order to d/c anti
G8209	Clinician did not doc
G8214	Clini not doc order VTE
G8217	Pt not received DVT proph
G8219	Received DVT proph day 2
G8220	Pt not rec DVT proph day 2
G8221	Pt inelig for DVT proph
G8223	Pt not doc for presc antipla
G8226	Pt no prescr anticoa at D/C
G8231	Pt not doc for admin t-PA
G8234	Pt not doc dysphagia screen
G8238	Pt not doc to rec rehab serv
G8240	Inter carotid stenosis30-99%
G8243	Pt not doc MRI/CT w/o lesion
G8246	Pt inelig hx w new/chg mole
G8248	Pt w/one alarm symp not doc
G8251	Pt not doc w/Barretts, endo
G8254	Pt w/no doc order for barium
G8257	Pt not doc rev meds D/C
G8260	Pt not doc to have dec maker
G8263	Pt not doc assess urinary in
G8266	Pt not doc charc urin incon
G8268	Pt not doc rec care urin inc
G8271	Pt no doc screen fall
G8274	Clini not doc pres/abs alarm
G8276	Pt not doc mole change
G8279	Pt not doc rec PE
G8282	Pt not doc to rec couns
G8285	Pt did not rec pres osteo
G8289	Pt not doc rec Ca/Vit D
G8293	COPD pt w/o spir results
G8296	COPD pt not doc bronch ther
G8298	Pt doc optic nerve eval
G8299	Pt not doc optic nerv eval
G8302	Pt doc w/ target IOP

Non-Covered HCPCS Codes	
Code	Brief Description
G8303	Pt not doc w/ IOP
G8304	Clin doc pt inelig IOP
G8305	Clin not prov care POAG
G8306	POAG w/ IOP rec care plan
G8307	POAG w/ IOP no care plan
G8308	POAG w/ IOP not doc plan
G8310	Pt not doc rec antiox
G8314	Pt not doc to rec mac exam
G8318	Pt doc not have visual func
G8322	Pt not doc pre axial leng
G8326	Pt not doc rec fundus exam
G8330	Pt not doc rec dilated mac
G8334	Doc of macular not giv MD
G8338	Clin not doc pt test osteo
G8341	Pt not doc for DEXA
G8345	Pt not doc have DEXA
G8351	Pt not doc ECG
G8354	Pt not rec aspirin prior ER
G8357	Pt not doc to have ECG
G8360	Pt not doc vital signs recor
G8362	Pt not doc 02 SAT assess
G8365	Pt not doc mental status
G8367	Pt not doc have empiric AB
G8370	Asthma pt w survey not docum
G8371	Chemother not rec stg3 colon
G8372	Chemother rec stg 3 colon ca
G8373	Chemo plan docum prior chemo
G8374	Chemo plan not doc prior che
G8375	CLL pt w/o doc flow cytometr
G8376	Brst ca pt inelig tamoxifen
G8377	MD doc colon ca pt inelig ch
G8378	MD doc pt inelig rad therapy
G8379	Radiat tx recom doc12mo ov
G8380	Pt w stgIC-3Brst ca w/o tam
G8381	Pt w stgIC-3Brst ca rec tam
G8382	MM pt w/o doc IV bisphophon
G8383	Radiation rec not doc 12mo o
G8384	MDS pt w/o base cytogen test
G8385	Diab pt w nodoc Hgb A1c 12m
G8386	Diab pt w nodoc LDL 12m
G8387	ESRD pt w Hct/Hgb not docume
G8388	ESRD pt w URR/Ktv not doc el

Non-Covered HCPCS Codes	
Code	Brief Description
G8389	MDS pt no doc Fe prior EPO
G8390	Diabetic w/o document BP 12m
G8391	Pt w asthma no doc med or tx
G8395	LVEF>=40% doc normal or mild
G8396	LVEF not performed
G8397	Dil macula/fundus exam/w doc
G8398	Dil macular/fundus not perfo
G8399	Pt w/DXA document or order
G8400	Pt w/DXA no document or orde
G8401	Pt inelig osteo screen measu
G8402	Smoke preven interven counse
G8403	Smoke preven nocounsel
G8404	Low extemity neur exam docum
G8405	Low extemity neur not perfor
G8406	Pt inelig lower extrem neuro
G8407	ABI documented
G8408	ABI not documented
G8409	Pt inelig for ABI measure
G8410	Eval on foot documented
G8415	Eval on foot not performed
G8416	Pt inelig footwear evaluatio
G8417	BMI >=30 calcuate w/followup
G8418	BMI < 22 calcuate w/followup
G8419	BMI>=30or<22 cal no followup
G8420	BMI<30 and >=22 calc & docu
G8421	BMI not calculated
G8422	Pt inelig BMI calculation
G8423	Pt screen flu vac & counsel
G8424	Flu vaccine not screen
G8425	Flu vaccine screen not curre
G8426	Pt not approp screen & counc
G8427	Doc meds verified w/pt or re
G8428	Meds document w/o verifica
G8429	Incomplete doc pt on meds
G8430	Pt inelig med check
G8431	Clin depression screen doc
G8432	Clin depression screen not d
G8433	Pt inelig for depression scr
G8434	Cognitive impairment screen
G8435	Cognitive screen not documen
G8436	Pt inelig for cognitive impa
G8437	Tx plan develop & document

Non-Covered HCPCS Codes	
Code	Brief Description
G8438	Tx plan develop & not docum
G8439	Pt inelig for co-develp tx p
G8440	Pain assessment document
G8441	No document of pain assess
G8442	Pt inelig pain assessment
G8443	Prescription by E-Prescrib s
G8445	Prescrip not gen at encounte
G8446	Some prescrib handwritten or
G8447	Pt visit doc using CCHIT cer
G8448	Pt visit docum w/non-CCHIT c
G8449	Pt not doc w/EMR due to syst
G8450	Beta-bloc rx pt w/abn lvef
G8451	Pt w/abn lvef inelig b-bloc
G8452	Pt w/abn lvef b-bloc no rx
G8453	Tob use cess int counsel
G8454	Tob use cess int no counsel
G8455	Current tobacco smoker
G8456	Smokeless tobacco user
G8457	Tobacco non-user
G8458	Pt inelig geno no antvir tx
G8459	Doc pt rec antivir treat
G8460	Pt inelig RNA no antvir tx
G8461	Pt rec antivir treat hep c
G8462	Pt inelig couns no antvir tx
G8463	Pt rec antiviral treat doc
G8464	Pt inelig; lo to no dter rsk
G8465	High risk recurrence pro ca
G8466	Pt inelig suic; MDD remis
G8467	New dx init/rec episode MDD
G8468	ACE/ARB rx pt w/abn lvef
G8469	Pt w/abn lvef inelig ACE/ARB
G8470	Pt w/ normal lvef
G8471	LVEF not performed/doc
G8472	ACE/ARB no rx pt w/abn lvef
G8473	ACE/ARB thxpy rx'd
G8474	ACE/ARB not rx'd; doc reas
G8475	ACE/ARB thxpy not rx'd
G8476	BP sys <130 and dias <80
G8477	BP sys>=130 and/or dias >=80
G8478	BP not performed/doc
G8479	MD rx'd ACE/ARB thxpy
G8480	Pt inelig ACE/ARB thxpy

Non-Covered HCPCS Codes	
Code	Brief Description
G8481	MD not rx'd ACE/ARB thxpy
G8482	Flu immunize order/admin
G8483	Flu imm no ord/admin doc rea
G8484	Flu immunize no order/admin
G8484	Report, Diabetes measures
G8485	Report, Prev Care Measures
G8486	Report CKD Measures
G8489	CAD measures grp
G8490	RA measures grp
G8491	HIV/AIDS measures grp
G8492	Prev Care measures grp
G8493	Back pain measures grp
G8494	DM meas qual act perform
G8495	CKD meas qual act perform
G8496	PC meas qual act perform
G8497	CABG meas qual act perform
G8498	CAD meas qual act perform
G8499	RA meas qual act perform
G8500	HIV meas qual act perform
G8501	Perio meas qual act perform
G8502	BP meas qual act perform
G8506	Pt rec ACE/ARB
G8507	Pt inelig pt verif meds
G8508	Pt inelig; pain asses no f/u
G8509	Pain assess no f/u pln doc
G8510	Pt inelig neg scrn depres
G8511	Clin depres scrn no f/u doc
G8518	Clin stg b/f lun/eso ca surg
G8519	Pt in; clin ca stg b/f surg
G8520	Clin stg b/f surg not doc
G8524	Patch closure conv CEA
G8525	No patch closure CEA
G8526	No patch closure conv CEA
G8530	Auto AV fistula recd
G8531	Pt inelig; auto AV fistula
G8532	No auto AV fistula; no reas
G8534	Doc elder mal scrn f/u plan
G8535	Pt inelig no eld mal scrn
G8536	No doc elder mal scrn
G8537	Pt inelig eldmal scrn no f/u
G8538	Eld mal scrn no f/u pln
G8539	Cur funct assess & care pln

Non-Covered HCPCS Codes	
Code	Brief Description
G8540	Pt inelig funct assess
G8541	No doc cur funct assess
G8542	Pt inelig func asses no pln
G8543	Cur funct asses; no care pln
G8544	CABG measures grp
G8545	HepC measures grp
G8546	CAP measures grp
G8547	IVD measures grp
G8548	HF measures grp
G8549	HepC MG qual act perform
G8550	CAP MG qual act perform
G8551	HF MG qual act perform
G8552	IVD MG qual act perform
G8553	1 Rx via qualified eRx sys
G8556	Ref to doc otolog eval
G8557	Pt inelig ref otolog eval
G8558	No ref to doc otolog eval
G8559	Pt ref doc oto eval
G8560	Pt hx act drain prev 90 days
G8561	Pt inelig for ref oto eval
G8562	Pt no hx act drain 90 d
G8563	Pt no ref oto reas no spec
G8564	Pt ref oto eval
G8565	Ver doc hear loss
G8566	Pt inelig ref oto eval
G8567	Pt no doc hear loss
G8568	Pt no ref otolo no spec
G8569	Prol intubation req
G8570	No prol intub req
G8571	Ster wd ifx 30 d postop
G8572	No ster wd ifx
G8573	Stk/CVA CABG
G8574	No strk/CVA CABG
G8575	Postop ren insuf
G8576	No postop ren insuf
G8577	Reop req bld grft oth
G8578	No reop req bld grft oth
G8579	Antplt med disch
G8580	Antplt med contraind
G8581	no antplt med disch
G8582	Bblock disch
G8583	Bblock contraind

Non-Covered HCPCS Codes	
Code	Brief Description
G8584	No bblock disch
G8585	Antilipid treat disch
G8586	Antlip disch contra
G8587	No antlipid treat disch
G8588	Sys BP <140
G8589	Sys BP >= 140
G8590	Dia BP < 90
G8591	Dia BP >= 90
G8592	No BP measure
G8593	Lipid pn results
G8594	No lipid prof perf
G8595	Ldl < 100
G8596	No LDL perf
G8597	Ldl >= 100
G8598	Asp therp used
G8599	No asp therp used
G8600	tPA initi w/in 3 hrs
G8601	No elig tPA init w/in 3 hrs
G8602	No tPA init w/in 3 hrs
G8603	Spok lang comp score
G8604	No high score spok lang
G8605	No spok lang comp score
G8606	Attention score
G8607	No high score attention
G8608	No attention score
G8609	Memory score
G8610	No high score memory
G8611	No memory score
G8612	Moto speech score
G8613	No high score moto speech
G8614	No moto speech score
G8615	Reading score
G8616	No high score reading
G8617	No reading score
G8618	Spok lang exp score
G8619	No high score spok lang exp
G8620	No spok lang exp score
G8621	Writing score
G8622	No high score writing
G8623	No writing score
G8624	Swallowing score
G8625	No high score swallowing

Non-Covered HCPCS Codes	
Code	Brief Description
G8626	No swallowing score
G8627	Surg proc w/in 30 days
G8628	No surg proc w/in 30 days
G8629	Doc antibio order b/4 surg
G8630	Doc antibio given b/4 surg
G8631	Pt no elg 4 order antbi give
G8632	Doc no antibi order b/4 surg
G8633	Pharm ther osteo rx
G8634	Pt no elg phar ther osteo
G8635	No pharm ther osteo rx
G8636	Flu immun admin/prev rec
G8637	Pt no elg receiv flu immun
G8638	Flu immun no admin/prev rec
G8639	Flu immun admin or prev rec
G8640	Pt no elg rec flu immun
G8641	Flu immun not admin/pre rec
G8642	Hrdshp rural w/o internet
G8643	Hrdshp w/o suff pharm w/eRx
G8644	EP no prescribe priv
G8645	Asthma measures grp
G8646	Asthma MG qual act perform
G8647	Fun stat score knee >= 0
G8648	Fun stat score knee < 0
G8649	Fun stat score knee pt noelg
G8650	Fun stat score knee not done
G8651	Fun stat score hip >= 0
G8652	Fun stat score hip < 0
G8653	Fun stat score hip pt no elg
G8654	Fun stat score hip not done
G8655	Fun stat score LE >= 0
G8656	Fun stat score LE < 0
G8657	Fun stat score LE pt no elg
G8658	Fun stat score LE not done
G8659	Fun stat score LS >= 0
G8660	Fun stat score LS < 0
G8661	Fun stat score LS pt no elg
G8662	Fun stat score LS not done
G8663	Fun stat score shdl >=0
G8664	Fun stat score shdl < 0
G8665	Fun stat score shdl pt no el
G8666	Fun stat score shdl not done
G8667	Fun stat score UE >=0

Non-Covered HCPCS Codes	
Code	Brief Description
G8668	Fun stat score UE < 0
G8669	Fun stat score UE pt no elg
G8670	Fun stat score UE not done
G8671	Fun stat score neck/TS >=0
G8672	Fun stat score neck/TS < 0
G8673	Fun stat scor nek/TS pt no e
G8674	Fun stat scor nek/TS not don
G8675	BP Syst >= 140 mmHg
G8676	BP Diast >= 90 mmHg
G8677	BP Syst < 130 mmHg
G8678	BP Syst >=130 - 139 mmHg
G8679	BP Diast < 80 mmHg
G8680	BP Diast 80-89 mmHg
G8681	Pt hosp w/HF
G8682	LVG test perf
G8683	Pt not elig for LVF test
G8684	Pt not hosp w/HF
G8685	LVF test not perf
G8686	Toba smkr curr or 2 hand exp
G8687	No tob smkr cur no 2 hnd exp
G8688	Smkls tob cur; no 2 hnd exp
G8689	Toba use not assess
G8690	Curr toba smkr or 2 hand exp
G8691	No cur tob smkr no 2 hnd exp
G8692	Curr smkls tob; no 2 hnd exp
G8693	Tobacco no assess
G9001	MCCD, initial rate
G9002	MCCD,maintenance rate
G9003	MCCD, risk adj hi, initial
G9004	MCCD, risk adj lo, initial
G9013	ESRD demo bundle level I
G9014	ESRD demo bundle-level II
G9016	Demo-smoking cessation coun
G9017	Amantadine HCL, oral
G9018	Zanamivir, inh pwdr
G9019	Oseltamivir phosp
G9020	Rimantadine HCL
G9033	Amantadine HCL oral brand
G9034	Zanamivir, inh pwdr, brand
G9035	Oseltamivir phosp, brand
G9036	Rimantadine HCL, brand
G9041	Low vision serv occupational

Non-Covered HCPCS Codes	
Code	Brief Description
G9042	Low vision orient/mobility
G9043	Low vision rehab therapist
G9044	Low vision rehab teacher
G9050	Oncology work-up evaluation
G9051	Oncology treatment decision
G9052	Onc surveillance for disease
G9053	Onc expectant management pt
G9054	Onc supervision palliative
G9055	Onc visit unspecified NOS
G9056	Onc prac mgmt adheres guide
G9057	Onc pract mgmt differs guide
G9058	Onc prac mgmt disagree w/gui
G9059	Onc prac mgmt pt opt alterna
G9060	Onc prac mgmt dif pt comorb
G9061	Onc prac cond noadd by guide
G9062	Onc prac guide differs nos
G9063	Onc dx nsclc stgI no dx prog
G9064	Onc dx nsclc stg2 no dx prog
G9065	Onc dx nsclc stg3A nodx prog
G9066	Onc dx nsclc stg3B-4 metasta
G9067	Onc dx nsclc dx unknown nos
G9068	Onc dx nsclc/sclc limited
G9069	Onc dx sclc/nsclc ext at dx
G9070	Onc dx sclc/nsclc ext unknwn
G9071	Onc dx brst stg1 2B no dx pr
G9072	Onc dx brst stg1-2 noprogres
G9073	Onc dx brst stg3-w/progres
G9074	Onc dx brst stg3-noprogress
G9075	Onc dx brst metastic/ recur
G9077	Onc dx prostate T1no progres
G9078	Onc dx prostate T2no progres
G9079	Onc dx prostate T3b-T4noprog
G9080	Onc dx prostate w/rise PSA
G9083	Onc dx prostate unknown NOS
G9084	Onc dx colon t1-3,n1-2,no pr
G9085	Onc dx colon T4, N0 w/o prog
G9086	Onc dx colon T1-4 no dx prog
G9087	Onc dx colon radiolg evid dx
G9088	Onc dx colon m1/mets w/o rad
G9089	Onc dx colon extent unknown
G9090	Onc dx rectal T1-2 no progr
G9091	Onc dx rectal T3 N0 no prog

Non-Covered HCPCS Codes	
Code	Brief Description
G9092	Onc dx rectal T1-3,N1-2noprg
G9093	Onc dx rectal T4,N,M0 no prg
G9094	Onc dx rectal M1 w/mets prog
G9095	Onc dx rectal extent unknwn
G9096	Onc dx esophag T1-T3 noprog
G9097	Onc dx esophageal T4 no prog
G9098	Onc dx esophageal mets recur
G9099	Onc dx esophageal unknown
G9100	Onc dx gastric no recurrence
G9101	Onc dx gastric p R1-R2noprog
G9102	Onc dx gastric unresectable
G9103	Onc dx gastric recurrent
G9104	Onc dx gastric unknown NOS
G9105	Onc dx pancreatc p R0 res no
G9106	Onc dx pancreatc p R1/R2 no
G9107	Onc dx pancreatic unresectab
G9108	Onc dx pancreatic unknwn NOS
G9109	Onc dx head/neck T1-T2no prg
G9110	Onc dx head/neck T3-4 noprog
G9111	Onc dx head/neck M1 mets rec
G9112	Onc dx head/neck ext unknown
G9113	Onc dx ovarian stg1A-B no pr
G9114	Onc dx ovarian stg1A-B or 2
G9115	Onc dx ovarian stg3/4 noprog
G9116	Onc dx ovarian recurrence
G9117	Onc dx ovarian unknown NOS
G9123	Onc dx NHL lge Bcell relap
G9124	Onc dx NHL relapse/refractor
G9125	Onc dx NHL stg unknown
G9126	Onc dx ovarian stg IA/B
G9128	Onc dx mult myeloma stg2 hig
G9129	Onc dx mult myeloma unkwn op
G9130	Onc dx multi myeloma unknown
G9131	Onc dx brst unknown NOS
G9132	Onc dx prostate mets no cast
G9133	Onc dx prostate clinical met
G9134	Onc NHLstg 1-2 no relap no
G9135	Onc dx NHL stg 3-4 not relap
G9136	Onc dx NHL trans to lg Bcell
G9137	Onc dx NHL relapse/refractor
G9138	Onc dx NHL stg unknown
G9139	Onc dx CML dx status unknown

Non-Covered HCPCS Codes	
Code	Brief Description
G9140	Frontier extended stay demo
H0016	Alcohol and/or drug services
H0021	Alcohol and/or drug training
H0022	Alcohol and/or drug interven
H0023	Alcohol and/or drug outreach
H0024	Alcohol and/or drug preventi
H0025	Alcohol and/or drug preventi
H0026	Alcohol and/or drug preventi
H0027	Alcohol and/or drug preventi
H0028	Alcohol and/or drug preventi
H0029	Alcohol and/or drug preventi
H0030	Alcohol and/or drug hotline
H0031	MH health assess by non-md
H0032	MH svc plan dev by non-md
H0033	Oral med adm direct observe
H0034	Med trng & support per 15min
H0035	MH partial hosp tx under 24h
H0036	Comm psy face-face per 15min
H0037	Comm psy sup tx pgm per diem
H0038	Self-help/peer svc per 15min
H0039	Asser com tx face-face/15min
H0040	Assert comm tx pgm per diem
H0041	Fos c chld non-ther per diem
H0042	Fos c chld non-ther per mon
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite not-in-home per diem
H0046	Mental health service, nos
H1010	Nonmed family planning ed
H1011	Family assessment
H2000	Comp multidisipln evaluation
H2001	Rehabilitation program 1/2 d
H2010	Comprehensive med svc 15 min
H2011	Crisis interven svc, 15 min
H2012	Behav Hlth Day Treat, per hr
H2013	Psych hlth fac svc, per diem
H2014	Skills Train and Dev, 15 min
H2015	Comp Comm Supp Svc, 15 min
H2016	Comp Comm Supp Svc, per diem
H2017	PsySoc Rehab Svc, per 15 min
H2018	PsySoc Rehab Svc, per diem
H2019	Ther Behav Svc, per 15 min

Non-Covered HCPCS Codes	
Code	Brief Description
H2020	Ther Behav Svc, per diem
H2021	Com Wrap-Around Sv, 15 min
H2022	Com Wrap-Around Sv, per diem
H2023	Supported Employ, per 15 min
H2024	Supported Employ, per diem
H2025	Supp Maint Employ, 15 min
H2026	Supp Maint Employ, per diem
H2027	Psychoed Svc, per 15 min
H2028	Sex Offend Tx Svc, 15 min
H2029	Sex Offend Tx Svc, per diem
H2030	MH Clubhouse Svc, per 15
H2031	MH Clubhouse Svc, per diem
H2032	Activity Therapy, per 15 min
H2033	Multisys Ther/Juvenile 15min
H2034	A/D Halfway House, per diem
H2035	A/D Tx Program, per hour
H2036	A/D Tx Program, per diem
H2037	Dev Delay Prev Dp Ch, 15 min
J0128	Abarelix injection
J0135	Adalimumab injection
J0190	Injection, biperiden, 2 mg
J0215	Alefacept
J0220	Aglucosidase alfa injection
J0278	Amikacin sulfate injection
J0390	Chloroquine injection
J0395	Arbutamine HCl injection
J0520	Bethanechol chloride inject
J0583	Bivalirudin
J0597	C-1 esterase, berinert
J0598	C1 esterase inhibitor inj
J0636	Inj calcitriol per 0.1 mcg
J0638	Canakinumab injection
J0706	Caffeine citrate injection
J0710	Cephapirin sodium injection
J0718	Certolizumab pegol inj
J0760	Colchicine injection
J0775	Collagenase, clost hist inj
J0795	Corticorelin ovine triflutal
J0970	Estradiol valerate injection
J1000	Depo-estradiol cypionate inj
J1051	Medroxyprogesterone inj
J1055	Medrxyprogester acetate inj

Non-Covered HCPCS Codes	
Code	Brief Description
J1056	MA/EC contraceptiveinjection
J1270	Injection, doxercalciferol
J1290	Ecallantide injection
J1300	Eculizumab injection
J1330	Ergonovine maleate injection
J1380	Estradiol valerate 10 MG inj
J1390	Estradiol valerate 20 MG inj
J1410	Inj estrogen conjugate 25 MG
J1430	Ethanolamine oleate 100 mg
J1435	Injection estrone per 1 MG
J1457	Gallium nitrate injection
J1458	Galsulfase injection
J1559	Hizentra injection
J1595	Injection glatiramer acetate
J1700	Hydrocortisone acetate inj
J1710	Hydrocortisone sodium ph inj
J1743	Idursulfase injection
J1810	Droperidol/fentanyl inj
J1890	Cephalothin sodium injection
J1930	Lanreotide injection
J1953	Levetiracetam injection
J2170	Mecasermin injection
J2180	Meperidine/promethazine inj
J2210	Methylergonovin maleate inj
J2271	Morphine so4 injection 100mg
J2278	Ziconotide injection
J2323	Natalizumab injection
J2325	Nesiritide injection
J2425	Palifermin injection
J2501	Paricalcitol
J2503	Pegaptanib sodium injection
J2504	Pegademase bovine, 25 iu
J2505	Injection, pegfilgrastim 6mg
J2590	Oxytocin injection
J2670	Totazoline hcl injection
J2675	Progesterone Injection
J2765	Injection, metoclopramide hcl
J2778	Ranibizumab injection
J2783	Rasburicase
J2793	Rilonacept injection
J2805	Sincalide injection
J2850	Inj secretin synthetic human

Non-Covered HCPCS Codes	
Code	Brief Description
J2940	Somatrem injection
J2941	Somatropin injection
J2950	Promazine hcl injection
J3110	Teriparatide injection
J3140	Testosterone suspension inj
J3150	Testosteron propionate inj
J3285	Treprostinil injection
J3310	Perphenazine injeciton
J3315	Triptorelin pamoate
J3350	Urea injection
J3355	Urofollitropin, 75 iu
J3364	Urokinase 5000 IU injection
J3385	Velaglucerase alfa
J3396	Verteporfin injection
J3400	Triflupromazine hcl inj
J3530	Nasal vaccine inhalation
J3570	Laetrile amygdalin vit B17
J7184	Wilate injection
J7300	Intraut copper contraceptive
J7302	Levonorgestrel iu contracept
J7303	Contraceptive vaginal ring
J7304	Contraceptive hormone patch
J7306	Levonorgestrel implant sys
J7307	Etonogestrel implant system
J7308	Aminolevulinic acid hcl top
J7518	Mycophenolic acid
J7628	Bitolterol mes inhal sol con
J7629	Bitolterol mes inh sol u d
J7635	Atropine inhal sol con
J7636	Atropine inhal sol unit dose
J7637	Dexamethasone inhal sol con
J7638	Dexamethasone inhal sol u d
J7642	Glycopyrrolate inhal sol con
J7643	Glycopyrrolate inhal sol u d
J7647	Isoetharine comp con
J7648	Isoetharine hcl inh sol con
J7649	Isoetharine hcl inh sol u d
J7650	Isoetharine comp unit
J7657	Isoproterenol comp con
J7658	Isoproterenolhcl inh sol con
J7659	Isoproterenol hcl inh sol ud
J7680	Terbutaline so4 inh sol con

Non-Covered HCPCS Codes	
Code	Brief Description
J7681	Terbutaline so4 inh sol u d
J8501	Oral aprepitant
J8515	Cabergoline, oral 0.25mg
J8565	Gefitinib oral
J9010	Alemtuzumab injection
J9025	Azacitidine injection
J9027	Clofarabine injection
J9035	Bevacizumab injection
J9055	Cetuximab injection
J9070	Cyclophosphamide 100 MG inj
J9080	Cyclophosphamide 200 MG inj
J9093	Cyclophosphamide lyophilized
J9094	Cyclophosphamide lyophilized
J9155	Degarelix injection
J9165	Diethylstilbestrol injection
J9175	Elliotts b solution per ml
J9219	Leuprolide acetate implant
J9225	Histrelin implant
J9226	Supprelin LA implant
J9303	Panitumumab injection
J9315	Romidepsin injection
J9357	Valrubicin, 200 mg
J9395	Injection, Fulvestrant
K0606	AED garment w elec analysis
K0607	Repl batt for AED
K0608	Repl garment for AED
K0609	Repl electrode for AED
K0730	Ctrl dose inh drug deliv sys
K0890	PWC gp5 ped sing pow opt s/b
K0891	PWC gp5 ped mult pow opt s/b
L1001	CTLSO infant immobilizer
L3201	Oxford w supinat/pronat inf
L3202	Oxford w/ supinat/pronator c
L3203	Oxford w/ supinator/pronator
L3204	Hightop w/ supp/pronator inf
L3206	Hightop w/ supp/pronator chi
L3207	Hightop w/ supp/pronator jun
L3208	Surgical boot each infant
L3209	Surgical boot each child
L3211	Surgical boot each junior
L3212	Benesch boot pair infant
L3213	Benesch boot pair child

Non-Covered HCPCS Codes	
Code	Brief Description
L3214	Benesch boot pair junior
L5856	Elec knee-shin swing/stance
L5857	Elec knee-shin swing only
L5858	Stance phase only
L5973	Ank-foot sys dors-plant flex
L6711	Ped term dev, hook, vol open
L6712	Ped term dev, hook, vol clos
L6713	Ped term dev, hand, vol open
L6714	Ped term dev, hand, vol clos
L7008	Pediatric electric hand
L7045	Pediatric electric hook
L7186	Electron elbow child switch
L7191	Elbow child myoelectronic ct
L8609	Artificial cornea
L8627	CID ext speech process repl
L8628	CID ext controller repl
L8629	CID transmit coil and cable
L8680	Implt neurostim elctr each
L8681	Pt prgrm for implt neurostim
L8682	Implt neurostim radiofq rec
L8683	Radiofq trsmtr for implt neu
L8684	Radiof trsmtr implt scrl neu
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8689	External recharging system
L8692	Non-osseointegrated snd proc
L8693	Aud osseo dev, abutment
M0075	Cellular therapy
M0076	Prolotherapy
M0100	Intragastric hypothermia
M0300	IV chelationtherapy
M0301	Fabric wrapping of aneurysm
P2031	Hair analysis
P7001	Culture bacterial urine
P9604	One-way allow prorated trip
Q0035	Cardiokymography
Q0144	Azithromycin dihydrate, oral
Q0478	Power adapter, combo vad
Q0479	Power module combo vad, rep
Q0480	Driver pneumatic vad, rep

Non-Covered HCPCS Codes	
Code	Brief Description
Q0481	Microprcsr cu elec vad, rep
Q0482	microprcsr cu combo vad, rep
Q0483	monitor elec vad, rep
Q0484	monitor elec or comb vad rep
Q0485	monitor cable elec vad, rep
Q0486	mon cable elec/pneum vad rep
Q0487	leads any type vad, rep only
Q0488	pwr pack base elec vad, rep
Q0489	pwr pck base combo vad, rep
Q0490	emr pwr source elec vad, rep
Q0491	emr pwr source combo vad rep
Q0492	emr pwr cbl elec vad, rep
Q0493	emr pwr cbl combo vad, rep
Q0494	emr hd pmp elec/combo, rep
Q0495	charger elec/combo vad, rep
Q0496	battery elec/combo vad, rep
Q0497	bat clps elec/comb vad, rep
Q0498	holster elec/combo vad, rep
Q0499	belt/vest elec/combo vad rep
Q0500	filters elec/combo vad, rep
Q0501	shwr cov elec/combo vad, rep
Q0502	mobility cart pneum vad, rep
Q0503	battery pneum vad replacemnt
Q0504	pwr adpt pneum vad, rep veh
Q0505	miscl supply/accessory vad
Q0506	Lith-ion batt elec/pneum VAD
Q0510	Dispens fee immunosupressive
Q0511	Sup fee antiem,antica,immuno
Q0512	Px sup fee anti-can sub pres
Q0513	Disp fee inhal drugs/30 days
Q0514	Disp fee inhal drugs/90 days
Q0515	Sermorelin acetate injection
Q2024	Bevacizumab injection, 0.25 mg
Q2026	Radiesse injection
Q2027	Sculptra injection
Q2035	Afluria vacc, 3 yrs & >, im
Q2036	Flulaval vacc, 3 yrs & >, im
Q2037	Fluvirin vacc, 3 yrs & >, im
Q2038	Fluzone vacc, 3 yrs & >, im
Q2039	NOS flu vacc, 3 yrs & >, im
Q3025	IM inj interferon beta 1-a
Q3026	Subc inj interferon beta-1a

Non-Covered HCPCS Codes	
Code	Brief Description
Q4007	Cast sup long arm ped, pl
Q4008	Cast sup, long arm ped, fib
Q4011	Cast sup sh arm ped, pl
Q4012	Cast sup sh arm ped, fib
Q4015	Cast sup gauntlet ped,
Q4016	Cast sup gauntlet ped, fib
Q4019	Cast sup l arm splint ped, pl
Q4020	Cast sup l arm splint ped, fib
Q4023	Cast sup sh arm splint ped, pl
Q4024	Cast sup sh arm splint ped, fib
Q4027	Cast sup hip spica, pl
Q4028	Cast sup, hip spica, fib
Q4031	Cast sup, long leg ped, pl
Q4032	Cast sup, long leg ped, fib
Q4035	Cast sup, leg cylinder ped, pl
Q4036	Cast sup, leg cylinder ped, fib
Q4039	Cast sup, sh leg ped, pl
Q4040	Cast sup, sh leg ped, fib
Q4043	Cast sup, l leg splintped, pl
Q4044	Cast sup, l leg splint ped, fib
Q4047	Cast sup, sh leg splint ped, pl
Q4048	Cast sup, sh leg splint ped, fib
Q4074	Iloprost non-comp unit dose
Q4082	Drug/bio NOC part B drug CAP
Q4117	Hyalomatrix
Q4118	Matristem micromatrix
Q4119	Matristem wound matrix
Q4120	Matristem burn matrix
Q4121	Theraskin
Q5002	Hospice in assisted living
S0012	Butorphanol tartrate, nasal
S0014	Tacrine hydrochloride, 10 mg
S0017	Injection, aminocaproic acid
S0020	Injection, bupivicaine hydro
S0021	Injection, ceftoperazone sod
S0023	Injection, cimetidine hydroc
S0028	Injection, famotidine, 20 mg
S0030	Injection, metronidazole
S0032	Injection, nafcillin sodium
S0034	Injection, ofloxacin, 400 mg
S0039	Injection, sulfamethoxazole
S0040	Injection, ticarcillin disod

Non-Covered HCPCS Codes	
Code	Brief Description
S0073	Injection, aztreonam, 500 mg
S0074	Injection, cefotetan disodiu
S0077	Injection, clindamycin phosp
S0078	Injection, fosphenytoin sodi
S0080	Injection, pentamidine iseth
S0081	Injection, piperacillin sodi
S0090	Sildenafil citrate, 25 mg
S0104	Zidovudine, oral, 100 mg
S0106	Bupropion hcl sr 60 tablets
S0108	Mercaptopurine 50 mg
S0109	Methadone oral 5 mg
S0117	Tretinoin topical, 5g
S0122	Inj menotropins 75 iu
S0126	Inj follitropin alfa 75 iu
S0128	Inj follitropin beta 75 iu
S0132	Inj ganirelix acetat 250 mcg
S0136	Clozapine, 25 mg
S0137	Didanosine, 25 mg
S0138	Finasteride, 5 mg
S0139	Minoxidil, 10 mg
S0140	Saquinavir, 200 mg
S0156	Exemestane, 25 mg
S0157	Becaplermin gel 1%, 0.5 gm
S0160	Dextroamphetamine
S0161	Calcitriol
S0166	Inj olanzapine 2.5mg
S0169	Calcitrol
S0177	Levamisole 50 mg
S0194	Vitamin suppl 100 caps
S0195	Pneumococcal conjugate vac
S0196	Poly-l-lactic acid 1ml face
S0197	Prenatal vitamins 30 day
S0201	Prt hosp svcs, less than 24 hrs, per diem
S0207	Parmedic intercept, non-hosp based
S0208	Paramed intrcept nonvol
S0209	WC van mileage per mi
S0215	Nonemerg transp mileage
S0220	Medical conference by physic
S0221	Medical conference, 60 min
S0250	Comp geriatr assmt team
S0255	Hospice refer visit nonmd
S0257	End of life counseling

Non-Covered HCPCS Codes	
Code	Brief Description
S0260	H&P for surgery
S0265	Genetic counsel 15 mins
S0270	Home std case rate 30 days
S0271	Home hospice case 30 days
S0272	Home episodic case 30 days
S0273	MD home visit outside cap
S0274	Nurse practr visit outs cap
S0280	Medical home, initial plan
S0281	Medical home, maintenance
S0302	Completed EPSDT
S0310	Hospitalist visit
S0315	Disease mgmt prgrm, init
S0316	Disease mgmt prgrm, flw up
S0317	Disease mgmt per diem
S0320	Phone call by RN to dis mgmt prgrm
S0340	Lifestyle mod 1st stage
S0341	Lifestyle mod 2 or 3 stage
S0342	Lifestyle mod 4th stage
S0390	Rout foot care per visit
S0400	Global eswl kidney
S0500	Dispos cont lens
S0504	Singl prscrp lens
S0506	Bifoc prscp lens
S0508	Trifoc prscrp lens
S0510	Non-prscrp lens
S0512	Daily cont lens
S0514	Color cont lens
S0515	Scleral lens liquid bandage
S0516	Safety frames
S0518	Sunglass frames
S0580	Polycarb lens
S0581	Nonstnd lens
S0590	Misc integral lens serv
S0592	Comp cont lens eval
S0595	New lenses in pts old frame
S0601	Screening proctoscopy
S0610	Annual gynecological examina
S0612	Annual gynecological examina
S0613	Ann breast exam
S0618	Audiometry for hearing aid
S0620	Routine ophthalmological exa
S0621	Routine ophthalmological exa

Non-Covered HCPCS Codes	
Code	Brief Description
S0622	Phys exam for college
S0625	Digital screening retinal
S0630	Removal of sutures
S0800	Laser in situ keratomileusis
S0810	Photorefractive keratectomy
S0812	Phototherap keratect
S1001	Deluxe item
S1002	Custom item
S1015	IV tubing extension set
S1016	Non-pvc intravenous administ
S1030	Gluc monitor purchase
S1031	Gluc monitor rental
S1040	Cranial remold orth, rigid
S2053	Transplantation of small int
S2054	Transplantation of multivisc
S2055	Harvesting of donor multivis
S2060	Lobar lung transplantation
S2061	Donor lobectomy (lung)
S2065	Simult panc kidn trans
S2066	Breast GAP flap reconst
S2067	Breast ÷stacked÷ DIEP/GAP
S2068	Breast DIEP flap reconstruct
S2070	Cysto laser tx ureteral calc
S2079	Lap esophagomyotomy
S2080	Laup
S2083	Adjustment gastric band
S2095	Transcath emboliz microspher
S2102	Islet cell tissue transplant
S2103	Adrenal tissue transplant
S2107	Adoptive immunotherapy
S2115	Periacetabular osteotomy
S2117	Arthroereisis, subtalar
S2118	Total hip resurfacing
S2120	Low density lipoprotein (LDL)
S2140	Cord blood harvesting
S2142	Cord blood-derived stem-cell
S2150	BMT harv/transpl 28d pkg
S2152	Solid organ transpl pkg
S2202	Echosclerotherapy
S2205	Minimally invasive direct co
S2206	Minimally invasive direct co
S2207	Minimally invasive direct co

Non-Covered HCPCS Codes	
Code	Brief Description
S2208	Minimally invasive direct co
S2209	Minimally invasive direct co
S2225	Myringotomy laser-assist
S2230	Implant semi-imp hear
S2235	Implant auditory brain imp
S2260	Induced abortion 17-24 weeks
S2265	Abortion for fetal ind, 25 – 28 wks
S2266	Abortion for fetal ind, 29 – 31 wks
S2267	Abortion for fetal ind, 32 wks or grtr
S2270	Insertion vaginal cylinder
S2300	Arthroscopy, shoulder, surgi
S2325	Hip core decompression
S2340	Chemodenervation of abductor
S2341	Chemodenerv adduct vocal
S2342	Nasal endoscop po debrid
S2344	Endosc balloon sinuplasty
S2348	Decompress disc RF lumbar
S2350	Diskectomy, anterior, with d
S2351	Diskectomy, anterior, with d
S2360	Vertebroplast cerv 1st
S2361	Vertebroplast cerv addl
S2400	Fetal surg congen hernia
S2401	Fetal surg urin trac obstr
S2402	Fetal surg cong cyst malf
S2403	Fetal surg pulmon sequest
S2404	Fetal surg myelomeningo
S2405	Fetal surg sacrococ teratoma
S2409	Fetal surg noc
S2411	Fetoscop laser ther TTTS
S2900	Robotic surgical system
S3000	Bilat dil retinal exam
S3005	Eval self-assess depression
S3620	Newborn metabolic screening
S3625	Maternal triple screen test
S3626	Maternal serum quad screen
S3628	PAMG-1 rapid assay for ROM
S3630	Eosinophil blood count
S3645	HIV-1 antibody testing of or
S3650	Saliva test, hormone level;
S3652	Saliva test, hormone level;
S3655	Antisperm antibody test
S3708	Gastrointestinal fat absorpt

Non-Covered HCPCS Codes	
Code	Brief Description
S3711	Circulating tumor cell test
S3713	Kras mutation analysis
S3800	Genetic testing ALS
S3818	BRCA1 gene anal
S3819	BRCA2 gene anal
S3820	Comp BRCA1/BRCA2
S3822	Sing mutation brst/ovar
S3823	3 mutation brst/ovar
S3828	Comp MLH1 gene
S3829	Comp MSH2 gene
S3830	Gene test HNPCC comp
S3831	Gene test HNPCC single
S3833	Comp APC sequence
S3834	Sing mutation APC
S3835	Gene test cystic fibrosis
S3837	Gene test hemochromato
S3840	DNA analysis RET-oncogene
S3841	Gene test retinoblastoma
S3842	Gene test Hippel-Lindau
S3843	DNA analysis Factor V
S3844	DNA analysis deafness
S3845	Gene test alpha-thalassemia
S3846	Gene test beta-thalassemia
S3847	Gene test Tay-Sachs
S3848	Gene test Gaucher
S3849	Gene test Niemann-Pick
S3850	Gene test sickle cell
S3851	Gene test Canavan
S3852	DNA analysis APOE Alzheimer
S3853	Gene test myo musclr dyst
S3854	Gene profile panel breast
S3855	Gene test presenilin-1 gene
S3860	Genet test cardiac ion-comp
S3861	Genetic test brugada
S3862	Genet test cardiac ion-spec
S3865	Comp genet test hyp cardiomy
S3865	comp genet test hyp cardiomy
S3866	Spec gene test hyp cardiomy
S3866	spec gene test hyp cardiomy
S3870	CGH test developmental delay
S3870	CGH test developmental delay
S3890	Fecal DNA analysis

Non-Covered HCPCS Codes	
Code	Brief Description
S3900	Surface EMG
S3902	Ballistocardiogram
S3904	Masters two step
S3905	Auto handheld diag nerv test
S4005	Interim labor facility global
S4011	IVF package
S4013	Compl gift case rate
S4014	Compl zift case rate
S4015	Complete IVF case rate
S4016	Frozen IVF case rate
S4017	INV canc a stim case rate
S4018	F EMB trns canc case rate
S4020	IVF canc a aspir case rate
S4021	IVF canc p aspir case rate
S4022	Asst oocyte fert case rate
S4023	Incompl donor egg case rate
S4025	Donor serv IVF case rate
S4026	Procure donor sperm
S4027	Store prev froz embryos
S4028	Microsurg epi sperm asp
S4030	Sperm procure init visit
S4031	Sperm procure subs visit
S4035	Stimulated iui case rate
S4037	Cryo embryo transf case rate
S4040	Monit store cryo embryo 30 d
S4042	Ovulation mgmt per cycle
S4981	Insert levonorgestrel ius
S4989	Contracept IUD
S4990	Nicotine patch legend
S4991	Nicotine patch nonlegend
S4993	Contraceptive pills for bc
S4995	Smoking cessation gum
S5000	Prescription drug, generic
S5001	Prescription drug,brand name
S5010	5% dextrose and 45% saline
S5011	5% dextrose in lactated ring
S5012	5% dextrose with potassium
S5013	5% dextrose/45%saline,1000ml
S5014	5% dextrose/45%saline,1500ml
S5035	HIT routine device maint
S5036	HIT device repair
S5100	Adult daycare services 15 min

Non-Covered HCPCS Codes	
Code	Brief Description
S5101	Adult day care per half day
S5102	Adult day care per diem
S5105	Centerbased daycare perdiem
S5108	Homecare train pt 15 min
S5109	Homecare train pt session
S5110	Family homecare training 15m
S5111	Family homecare train/sessio
S5115	Nonfamily homecare train/15m
S5116	Nonfamily HC train/session
S5120	Chore services per 15 min
S5121	Chore services per diem
S5125	Attendant care service /15m
S5126	Attendant care service /diem
S5130	Homaker service nos per 15m
S5131	Homemaker service nos /diem
S5135	Adult companioncare per 15m
S5136	Adult companioncare per diem
S5140	Adult foster care per diem
S5141	Adult foster care per month
S5145	Child fostercare th per diem
S5146	Ther fostercare child /month
S5150	Unskilled respite care /15m
S5151	Unskilled respitecare /diem
S5165	Home modifications per serv
S5170	Homedelivered prepared meal
S5175	Laundry serv,ext,prof,/order
S5180	HH respiratory thrpy in eval
S5181	HH respiratory thrpy nos/day
S5185	Med reminder serv per month
S5190	Wellness assessment by nonph
S5199	Personal care item nos each
S5497	HIT cath care noc
S5498	HIT simple cath care
S5501	HIT complex cath care
S5502	HIT interim cath care
S5517	HIT declotting kit
S5518	HIT cath repair kit
S5520	HIT picc insert kit
S5521	HIT midline cath insert kit
S5522	HIT picc insert no supp
S5523	HIP midline cath insert kit
S5550	Insulin rapid 5 u

Non-Covered HCPCS Codes	
Code	Brief Description
S5551	Insulin most rapid 5 u
S5552	Insulin intermed 5 u
S5553	Insulin long acting 5 u
S5560	Insulin reuse pen 1.5 ml
S5561	Insulin reuse pen 3 ml
S5565	Insulin cartridge 150 u
S5566	Insulin cartridge 300 u
S5570	Insulin dispos pen 1.5 ml
S5571	Insulin dispos pen 3 ml
S8030	Tantalum ring application
S8035	Magnetic source imaging
S8037	mrcp
S8040	Topographic brain mapping
S8042	MRI low field
S8049	Intraoperative radiation the
S8055	Us guidance fetal reduct
S8080	Scintimammography
S8085	Fluorine-18 fluorodeoxygluco
S8092	Electron beam computed tomog
S8096	Portable peak flow meter
S8097	Asthma kit
S8100	Spacer without mask
S8101	Spacer with mask
S8110	Peak expiratory flow rate (p
S8120	O2 contents gas cubic ft
S8121	O2 contents liquid lb
S8185	Flutter device
S8186	Swivel adaptor
S8189	Trach supply noc
S8210	Mucus trap
S8262	Mandib ortho repos device
S8265	Haberman feeder
S8270	Enuresis alarm
S8301	Infect control supplies NOS
S8415	Supplies for home delivery
S8450	Splint digit
S8451	Splint wrist or ankle
S8452	Splint elbow
S8460	Camisole post-mast
S8490	100 insulin syringes
S8940	Hippotherapy per session
S8948	Low-level laser trmt 15 min

Non-Covered HCPCS Codes	
Code	Brief Description
S8950	Complex lymphedema therapy,
S8990	PT or manip for maint
S8999	Resuscitation bag
S9001	Home uterine monitor with or
S9007	Ultrafiltration monitor
S9015	Automated EEG monitoring
S9024	Paranasal sinus ultrasound
S9025	Omnicardiogram/cardiointegra
S9034	ESWL for gallstones
S9055	Procuren or other growth fac
S9056	Coma stimulation per diem
S9061	Medical supplies and equipme
S9075	Smoking cessation treatment
S9083	Urgent care center global
S9088	Services provided in urgent
S9090	Vertebral axial decompressio
S9097	Home visit wound care
S9098	Home phototherapy visit
S9109	CHF telemonitoring month
S9117	Back school visit
S9125	Respite care, in the home, p
S9126	Hospice care, in the home, p
S9127	Social work visit, in the ho
S9128	Speech therapy, in the home,
S9129	Occupational therapy, in the
S9131	PT in the home per diem
S9140	Diabetic Management Program,
S9141	Diabetic Management Program,
S9145	Insulin pump initiation
S9150	Evaluation by Ocularist
S9152	Speech therapy, re-eval
S9208	Home mgmt preterm labor
S9209	Home mgmt PPROM
S9211	Home mgmt gest hypertension
S9212	Hm postpar hyper per diem
S9213	Hm preeclamp per diem
S9214	Hm gest dm per diem
S9325	HIT pain mgmt per diem
S9326	HIT cont pain per diem
S9327	HIT int pain per diem
S9328	HIT pain imp pump diem
S9329	HIT chemo per diem

Non-Covered HCPCS Codes	
Code	Brief Description
S9330	HIT cont chem diem
S9331	HIT intermit chemo diem
S9335	HT hemodialysis diem
S9336	HIT cont anticoag diem
S9338	HIT immunotherapy diem
S9339	HIT periton dialysis diem
S9340	HIT enteral per diem
S9341	HIT enteral grav diem
S9342	HIT enteral pump diem
S9343	HIT enteral bolus nurs
S9345	HIT anti-hemophil diem
S9346	HIT alpha-1-proteinas diem
S9347	HIT longterm infusion diem
S9348	HIT sympathomim diem
S9349	HIT tocolysis diem
S9351	HIT cont antiemetic diem
S9353	HIT cont insulin diem
S9355	HIT chelation diem
S9357	HIT enzyme replace diem
S9359	HIT anti-tnf per diem
S9361	HIT diuretic infus diem
S9363	HIT anti-spasmotic diem
S9364	HIT tpn total diem
S9365	HIT tpn 1 liter diem
S9366	HIT tpn 2 liter diem
S9367	HIT tpn 3 liter diem
S9368	HIT tpn over 3l diem
S9370	HT inj antiemetic diem
S9372	HT inj anticoag diem
S9373	HIT hydra total diem
S9374	HIT hydra 1 liter diem
S9375	HIT hydra 2 liter diem
S9376	HIT hydra 3 liter diem
S9377	HIT hydra over 3l diem
S9379	HIT noc per diem
S9381	HIT high risk/escort
S9401	Anticoag clinic per session
S9430	Pharmacy comp/disp serv
S9433	Medical food oral 100% nutr
S9434	Mod solid food suppl
S9435	Medical foods for inborn err
S9436	Lamaze class

Non-Covered HCPCS Codes	
Code	Brief Description
S9437	Childbirth refresher class
S9438	Cesarean birth class
S9439	VBAC class
S9441	Asthma education
S9442	Birthing class
S9443	Lactation class
S9444	Parenting class
S9446	PT education noc group
S9447	Infant safety class
S9449	Weight mgt class
S9451	Exercise class
S9452	Nutrition class
S9453	Smoking cessation class
S9454	Stress mgmt class
S9455	Diabetic Management Program,
S9460	Diabetic Management Program,
S9465	Diabetic Management Program,
S9470	Nutritional counseling, diet
S9472	Cardiac rehabilitation progr
S9473	Pulmonary rehabilitation pro
S9474	Enterostomal therapy by a re
S9475	Ambulatory setting substance
S9476	Vestibular rehab per diem
S9480	Intensive outpatient psychia
S9482	Family stabilization 15 min
S9484	Crisis intervention per hour
S9485	Crisis intervention mental h
S9490	HIT corticosteroid diem
S9494	HIT antibiotic total diem
S9497	HIT antibiotic q3h diem
S9500	HIT antibiotic q24h diem
S9501	HIT antibiotic q12h diem
S9502	HIT antibiotic q8h diem
S9503	HIT antibiotic q6h diem
S9504	HIT antibiotic q4h diem
S9529	Venipuncture home/snf
S9537	HT hem horm inj diem
S9538	HIT blood products diem
S9542	HT inj noc per diem
S9558	HT inj growth horm diem
S9559	HIT inj interferon diem
S9560	HT inj hormone diem

Non-Covered HCPCS Codes	
Code	Brief Description
S9562	Palivizumab home inj perdiem
S9590	In home irrigation therapy
S9810	HT pharm per hour
S9900	Christian sci pract visit
S9970	Health club membership yr
S9975	Transplant related per diem
S9976	Lodging per diem
S9977	Meals per diem
S9981	Med record copy admin
S9986	Not medically necessary svc
S9988	Serv part of phase I trial
S9989	Services outside US
S9990	Services provided as part of
S9991	Services provided as part of
S9992	Transportation costs to and
S9994	Lodging costs (e.g. hotel ch
S9996	Meals for clinical trial par
S9999	Sales tax
T1000	Priv duty/inde nurse, to 15 mi
T1001	Nursing assessement/eval
T1002	RN services, up to 15 min
T1003	LPN/LVN serv, up to 15 min
T1004	Nurs aide serv, up to 15 min
T1005	Respite care, up to 15 min
T1006	Family/couple counseling
T1007	Treatment plan development
T1009	Child sitting services
T1010	Meals when receive services
T1012	Alcohol/subs abs, skills dev
T1013	Sign lang or oral intrpr serv
T1014	Telehealth transmit, per min
T1016	Case management
T1017	Targeted case management
T1018	School-based IEP ser bundled
T1019	Personal care ser per 15 min
T1020	Personal care ser per diem
T1021	HH aide or CN aide per visit
T1022	Contracted services per day
T1023	Program intake assessment
T1024	Team evaluation & management
T1025	Ped compr care pkg, per diem
T1026	Ped compr care pkg, per hour

Non-Covered HCPCS Codes	
Code	Brief Description
T1027	Family training & counseling
T1028	Home environment assessment
T1029	Dwelling lead investigation
T1030	RN home care per diem
T1031	LPN home care per diem
T1502	Medication admin visit
T1503	Med admin other than oral
T1505	Elec med comp dev, noc
T1999	NOC retail items andsupplies
T2001	N-et; patient attend/escort
T2002	N-et; per diem
T2003	N-et; encounter/trip
T2004	N-et; commerc carrier, pass
T2005	N-et; stretcher van
T2007	Non-emer transport wait time
T2010	PASRR LEVEL I
T2011	PASRR LEVEL II
T2012	Habil ed waiver, per diem
T2013	Habil ed waiver per hour
T2014	Habil prevoc waiver, per d
T2015	Habil prevoc waiver per hr
T2016	Habil res waiver per diem
T2017	Habil res waiver 15 min
T2018	Habil sup empl waiver/diem
T2019	Habil sup empl waiver 15min
T2020	Day habil waiver per diem
T2021	Day habil waiver per 15 min
T2022	Case management, per month
T2023	Targeted case mgmt per month
T2024	Serv asmnt/care plan waiver
T2025	Waiver service, nos
T2026	Special childcare waiver/d
T2027	Spec childcare waiver 15 min
T2028	Special supply, nos waiver
T2029	Special med equip, noswaiver
T2030	Assist living waiver/month
T2031	Assist living waiver/diem
T2032	Res care, nos waiver/month
T2033	Res, nos waiver per diem
T2034	Crisis interven waiver/diem
T2035	Utility services waiver
T2036	Camp overnite waiver/session

Non-Covered HCPCS Codes	
Code	Brief Description
T2037	Camp day waiver/session
T2038	Comm trans waiver/service
T2039	Vehicle mod waiver/service
T2040	Financial mgt waiver/15min
T2041	Support broker waiver/15 min
T2042	Hospice routine home care
T2043	Hospice continuous home care
T2044	Hospice respite care
T2045	Hospice general care
T2046	Hospice long term care, r&b
T2048	Bh ltc res r&b, per diem
T2049	N-ET; stretcher van, mileage
T2101	Breast milk proc/store/dist
T4529	Ped size brief/diaper sm/med
T4530	Ped size brief/diaper lg
T4531	Ped size pull-on sm/med
T4532	Ped size pull-on lg
T4538	Diaper serv reusable diaper
T4543	Disp bariatric brief/diaper
T5001	Special position seat/vehicl
T5999	Supply, nos
V2788	Presbyopia-correct function
V5090	Hearing aid dispensing fee
V5095	Implant mid ear hearing pros
V5110	Hearing aid dispensing fee
V5262	Hearing aid, disp, monaural
V5263	Hearing aid, disp, binaural
V5265	Ear mold/insert, disp
V5268	ALD Telephone Amplifier
V5269	Alerting device, any type
V5270	ALD, TV amplifier, any type
V5271	ALD, TV caption decoder
V5272	Tdd
V5273	ALD for cochlear implant
V5274	ALD unspecified
V5275	Ear impression
V5298	Hearing aid noc
V5299	Hearing service

NON-COVERED MODIFIERS

All five-digit CPT® modifiers (e.g. 09951)

–AJ Clinical Social Worker

–Q6 Locum Tenens

–SU Procedure Performed in Physician's Office (to denote use of facility and equipment)

APPENDIX E
MODIFIERS THAT AFFECT PAYMENT

Only modifiers that affect payment are listed in this section. Refer to current CPT® and HCPCS books for complete modifier descriptions and instructions.

CPT® MODIFIERS

–22 Unusual services
Procedures with this modifier may be individually reviewed prior to payment. A report is required for this review. Payment varies based on the report submitted.

–24 Unrelated evaluation and management (E/M) services by the same physician during a postoperative period
Used to indicate an evaluation and management service unrelated to the surgical procedure was performed during a postoperative period. *Documentation must be submitted with the billing form when this modifier is used.* Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

–25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure
Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less. Refer to the Professional Services section for information on the use of modifier –25.

–26 Professional component
Certain procedures are a combination of the professional (–26) and technical (–TC) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the –26 nor the –TC modifier should be used.

–50 Bilateral surgery
The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. Payment is made at one hundred fifty percent of the global surgery fee for the procedure. Providers must bill using two line items on the bill form. The modifier –50 should be applied to the second line item.

–51 Multiple surgeries
For procedure codes that represent multiple surgical procedures, payment is made based on the fee schedule allowance associated with that code. Refer to the global surgery rules for additional information.

–52 Reduced services
Payment is made at the fee schedule level or billed charge, whichever is less.

–53 Discontinued services
CMS has established reduced RVUs for CPT® code 45378 when billed with modifier –53. L&I prices this code-modifier combination according to those RVUs.

–54 Surgical care only [(1)]
When one physician performs a surgical procedure and another provides preoperative and/or postoperative management.

–55 Postoperative management only [(1)]
When one physician performs the postoperative management and another physician has performed the surgical procedure.

–56 Preoperative management only [(1)]

When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure.

When providing less than the global surgical package providers should use modifiers –54, –55, and –56. These modifiers are designed to ensure that the sum of all allowances for all providers doesn't exceed the total allowance for the global surgery period. These modifiers allow direct payment to the provider of each portion of the global surgery services.

–57 Decision for surgery

Used only when the decision for surgery was made during the preoperative period of a surgical procedure with a global surgery follow-up period. It should not be used with visits furnished during the global period of minor procedures (0-10 day global period) unless the purpose of the visit is a decision for major surgery. Separate payment should be made even if the visit falls within the global surgery period. No separate documentation is needed when submitting a billing form with this modifier.

–62 Two surgeons

For surgery requiring the skills of two surgeons (usually with a different specialty), each surgeon is paid at 62.5% of the global surgical fee. No payment is made for an assistant-at-surgery in these cases.

–66 Team surgery

Used when highly complex procedures are carried out by a surgical team. This may include the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Supporting documentation is required for this review.

–78 Return to the operating room for a related procedure during the postoperative period

Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

–79 Unrelated procedure or service by the same physician during the postoperative period

Use of this modifier allows separate payment for procedures not associated with the original surgery. Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

–80 Assistant surgeon [(2)]

–81 Minimum assistant surgeon [(2)]

–82 Assistant surgeon (when qualified resident surgeon not available) [(2)]

Assistant Surgeon Modifiers. Physicians who assist the primary physician in surgery should use modifiers –80, –81 or –82 depending on the medical necessity. Payment for procedures with these modifiers is made at the billed charge or twenty percent of the global surgery amount for the procedure, whichever is less. Refer to the assistant surgeon indicator in the Professional Services Fee Schedule to determine if assistant surgeon fees are payable.

–91 Repeat clinical diagnostic laboratory test performed on the same day to obtain subsequent reportable test values(s) (separate specimens taken in separate encounters)

Payment will be made for repeat test(s) performed for the same patient on the same day when specimen(s) have been taken from separate encounters. Test(s) normally performed as a series, e.g. glucose tolerance test don't qualify as separate encounters.

The medical necessity for repeating the test(s) must be documented in the patient record.

–99 Multiple modifiers
This modifier should only be used when two or more modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the services performed. For billing purposes, only modifier –99 should go in the modifier column, with the individual descriptive modifiers that affect payment listed elsewhere on the billing form.

HCPCS MODIFIERS

–GT Teleconsultations via interactive audio and video telecommunication systems
Payment policies for teleconsultations are located in the Professional Services section.

–LT Left side
Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

–NU New Purchased DME
Use the –NU modifier when a new DME item is to be purchased.

–RR Rented DME
Use the –RR modifier when DME is to be rented.

–RT Right side
Although this modifier doesn't affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

–SG Ambulatory surgical center (ASC) facility service
Bill the appropriate CPT® surgical code(s) adding this modifier –SG to each surgery code.

–TC Technical component
Certain procedures are a combination of the professional (–26) and technical (–TC) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the –26 nor –TC modifier should be used. Refer to the CPT® modifier section for the use of the –26 modifier.

LOCAL MODIFIER

–1S Surgical dressings for home use
Bill the appropriate HCPCS code for each dressing item using this modifier –1S for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.

–3R Billing for advanced imaging procedures
This code is billed by gold card providers when billing advanced imaging procedures subject to utilization review.

APPENDIX F
OUTPATIENT DRUG FORMULARY

The following is a list of drugs and therapeutic classes (or class codes) and their status on L&I's outpatient formulary. The formulary may change from time to time to reflect the Washington State Pharmacy and Therapeutics (P&T) Committee's recommendations or administrative changes.

PLEASE NOTE:

- This is an outpatient drug formulary. Many of the drugs not included on the formulary may be appropriate in other settings, such as inpatient, outpatient surgery, emergency room, and clinics or offices, and are covered when billed appropriately.
- Drugs listed on the formulary don't guarantee coverage and may be subject to the department's policy and appropriateness for the accepted conditions.
- Status of the therapeutic classes depends on the drugs' approved indication and is as followed:
  - A = Allowed
  - PA = Prior Authorization required
  - D = Denied
- Drugs that are included in the Washington State's evidence-based Preferred Drug List (PDL) may be subject to the provisions of the Therapeutic Interchange Program (TIP).

L&I Preferred Drug List

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	D4J	Proton Pump Inhibitors	Omeprazole magnesium (generics only) Omeprazole (generics only)
A	H2E	Non-Barbiturate, Sedative-Hypnotics ***Acute use only***	
		Benzodiazepine Receptor Agonists	Zaleplon (generics only) Zolpidem (generics only)
A	H3A	Analgesics, Narcotics	
		Long Acting Opioids	Methadone (generics only) Morphine Sulfate ER/SA (generics only)
A	H6H	Skeletal Muscle Relaxants ***Effective January 1, 2011***	Baclofen (generics only) Cyclobenzaprine (generics only) Methocarbamol (generics only) Tizanidine (generics only) ****Carisoprodol products are non-covered****

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	H2S H7B H7C H7D	Second Generation Antidepressants	
		Serotonin Specific Reuptake Inhibitors (SSRI's) ***Effective April 1, 2010***	Citalopram (generics only) Fluoxetine (generics only) Fluvoxamine (generics only) Paroxetine/CR (generics only) Sertraline (generics only)
		Alpha-2 Receptor Antagonists	Mirtazapine (generics only)
		Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	Venlafaxine (generics only) Venlafaxine ER
		Norepinephrine & Dopamine Reuptake Inhibitors (NDRIs)	Bupropion/SR/XL (generics only)
A	H7T H7X	Atypical Antipsychotic	
		Antipsychotic, Atypical, Dopamine & Serotonin ***Effective January 1, 2011***	Asenapine (Saphris) Clozapine (generics only) Clozapine oral disintegrating (FazaClo) Iloperidone (Fanapt) Olanzapine (Zyprexa/Zydis) Paliperidone (Invega) Quetiapine (Seroquel/XR) Risperidone (generics only) Ziprasidone (Geodon)
		Antipsychotic, Atypical, D2 Partial Agonist/ 5HT Mix	Aripiprazole(Abilify/Discmelt)
A	J5D	Beta Adrenergic Agents (Inhalations)	
		Short Acting Beta Agonists	Albuterol sulfate solution (generics only) Albuterol sulfate HFA (Ventolin, Proventil, Proair)
		Long Acting Beta Agonists	Formoterol aerolizer (Foradil) Salmeterol diskus (Serevent)
A	J5G	Beta-Adrenergics & Glucocorticoids Combination	Budesonide/Formoterol (Symbicort) Fluticasone/Salmeterol (Advair Diskus/HFA)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	P5A	Glucocorticoids	
		Inhaled Corticosteroids	Beclomethasone dipropionate MDI (Qvar) Budesonide DPI/nebulizer solution (Pulmicort Respules/Flexhaler) Flunisolide MDI (Aerobid/Aerobid-M) Fluticasone propionate MDI/DPI (Flovent Diskus/HFA)
A	Q7P	Nose Preparations, Anti-inflammatory Steroids ***Effective April 1, 2010***	Flunisolide (generics only) Fluticasone (generics only)
A	R1A	Urinary Tract Antispasmodic Agents	Oxybutynin/ER (generics only)
A	R1I	Urinary Tract Antispasmodic, M(3) Selective Antagonists	Solifenacin (Vesicare)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	S2B	NSAIDs, Cyclooxygenase Inhibitors	Diclofenac Potassium/Sodium (generics only) Etodolac/XL (generics only) Fenoprofen (generics only) Flurbiprofen (generics only) Ibuprofen (generics only) Indomethacin (generics only) Ketoprofen (generics only) Ketorolac (generics only) Meclofenamate (generics only) Meloxicam (generics only) Nabumetone (generics only) Naproxen/Sodium (generics only) Piroxicam (generics only) Oxaprozin (generics only) Sulindac (generics only) Tolmetin (generics only)
A	W1D	Macrolides	Azithromycin (generics only) Clarithromycin/Suspension (generics only) Erythromycin (generics only) Erythromycin EC (generics only) Erythromycin ethylsuccinate (generics only) Erythromycin stearate (generics only)
A	Z2Q	Antihistamines – 2nd Generation ***Effective January 1, 2011***	Cetirizine (generics only) Loratadine OTC (generics only)
A	Z4B Z4E	Leukotriene Modifier	
		Leukotriene Receptor Antagonists	Montelukast (Singulair)
		5-Lipoxygenase Inhibitor	

L&I Wrap-around Formulary

Compound Drugs

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	000	Compound Drugs	None

Cardiovascular System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	A1A	Digitalis Glycosides	None
A	A1B	Xanthines	Caffeine (generics only) Aminophylline (generics only) Theophylline/SA (generics only) Theophylline anhydrous/SR (generics only)
D	A1C	Inotropic Drugs	None
A	A1D	General Bronchodilator Agents	Ipratropium Bromide (generics only)
D	A1E	Xanthines & Dietary Supplement Combinations	None
PA	A2A	Antiarrhythmics	None
PA	A2C	Antianginal & Anti-ischemic Agents, Non-hemodynamic	None
PA	A4A	Hypotensives-Vasodilators	None
PA	A4B	Hypotensives-Sympatholytic	None
PA	A4D	Hypotensives-Angiotensin Converting Enzyme Blockers	None
PA	A4F	Hypotensives, Angiotensin Receptor Antagonist	None
PA	A4H	Angiotensin Receptor Antagonist & Calcium Channel Blockers	None
PA	A4I	ACE Inhibitor/Thiazide and Thiazide-like Diuretic Combination	None
PA	A4J	Angiotensin Receptor Antagonist/Thiazide and Thiazide-related Diuretic Combinations	None
PA	A4K	ACE Inhibitor/Calcium Channel Blocker Combination	None
PA	A4T	Renin Inhibitor, Direct	None
PA	A4Y	Hypotensives-Miscellaneous	None
D	A6U	Cardiovascular Diagnostics	None
D	A6V	Cardiovascular Diagnostics – Non Radiopaque	None
PA	A7B	Coronary Vasodilators	None
PA	A7C	Peripheral Vasodilators	None
PA	A7E	Vasodilators-Miscellaneous	None
PA	A7J	Vasodilators, Combination	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	A8O	Venosclerosing Agents	None
PA	A9A	Calcium Channel Blocking Agents	None

Respiratory System

Status	TCC	Description	Preferred Drug(s)
A	B0A	Miscellaneous Respiratory Inhalants	Sodium Chloride (generics only)
D	B1A	Lung Surfactants	None
D	B1B	Pulm Antihypertensive, Endothelin Receptor Antagonist-Type	None
PA	B1C	Pulmonary Antihypertensives, Prostaglandin Type	None
PA	B1D	Pulmonary Antihypertensives, Selective C-GMP Phosphodiesterase T5 Inh.	None
PA	B1E	Pulmonary Antihypertensives, CGMP Pathway, Gases	None
A	B3A	Mucolytics	Acetylcysteine (generics only)
A	B3J	Expectorants	Guaifenesin (generics only)
PA	B3K	Cough and Cold Preparations	None
PA	B3N	Decongestant-Analgesic-Expectorant Combination	None
PA	B3O	1st Generation Antihistamine-Decongestant- Analgesic Combination	None
PA	B3P	Non-narcotic Antitussive-1st Generation Antihistamine-Decongestant-Analgesic Combination	None
PA	B3Q	Narcotic Antitussive-1st Generation Antihistamine-Decongestant Combination	None
PA	B3R	Non-narcotic Antitussive-1st Generation Antihistamine-Decongestant Combination	None
PA	B3S	Non-narcotic Antitussive-1st Generation Antihistamine-Decongestant Expectorant Combination	None
PA	B3T	Non-narcotic Antitussive and Expectorant Combination	None
PA	B3V	1st Generation Antihistamine-Decongestant-Analgesic-Expectorant Combination	None
PA	B3X	1st Generation Antihistamine-Decongestant-Anticholinergic Combination	None
PA	B3Y	1st Generation Antihistamine-Decongestant-Analgesic-Expectorant Combination	None
PA	B4A	Non-narcotic Antitussive-Analgesic Combination	None

Status	TCC	Description	Preferred Drug(s)
PA	B4C	Narcotic Antitussive-Anticholinergic Combination	None
PA	B4D	Narcotic Antitussive-1st Generation Antihistamine Combination	None
A	B4E	Non-narcotic Antitussive-1st Generation Antihistamine Combination	Promethazine/Dextromethorphan (generics only)
PA	B4G	Non-narcotic Antitussive-1st Generation Antihistamine-Analgesic Combination	None
PA	B4H	Narcotic Antitussive-1st Generation Antihistamine-Expectorant Combination	None
PA	B4I	Non-narcotic Antitussive-1st Generation Antihistamine-Expectorant Combination	None
PA	B4J	Narcotic Antitussive-1st Generation Antihistamine-Decongestant-Expectorant Combination	None
PA	B4K	Narcotic Antitussive-Decongestant Combination	None
PA	B4L	Non-narcotic Antitussive-Decongestant	None
PA	B4M	Non-narcotic Antitussive-Decongestant-Analgesic Combination	None
PA	B4N	Narcotic Antitussive-1st Generation Antihistamine-Decongestant-Analgesic Combination	None
PA	B4P	Non-narcotic Antitussive-1st Generation Antihistamine-Analgesic-Expectorant Combination	None
PA	B4Q	Narcotic Antitussive-Decongestant-Expectorant Combination	None
PA	B4R	Non-narcotic Antitussive-Decongestant-Expectorant Combination	None
PA	B4S	Narcotic Antitussive-Expectorant Combination	None
PA	B4T	Decongestant-Analgesic, Non-salicylate Combination	None
PA	B4U	Decongestant-Anticholinergic Combination	None
A	B4W	Decongestant-Expectorant Combination	Guaifenesin/Pseudoephedrine (generics only) Guaifenesin/Phenylpropanolamine (generics only)
PA	B4X	Expectorant Combination, Other	None
PA	B5E	Decongestant-Analgesic, Mixed-Xanthine Combination	None
PA	B5F	Decongestant-Analgesics, Salicylate Combination	None
PA	B5G	Decongestant-NSAID, COX Non-specific Combination	None

Status	TCC	Description	Preferred Drug(s)
PA	B5H	1st Generation Antihistamine-Decongestant-NSAID, COX Non-specific Combination	None
PA	B5K	Decongestant-Analgesic, Salicylate-Xanthine Combination	None
PA	B5J	Decongestant-Analgesic, Non-salicylate-Xanthine Combination	None
PA	B5M	1st Generation Antihistamine-Decongestant-Analgesic, Mixed	None
PA	B5N	1st Generation Antihistamine-Decongestant-Analgesic, Salicylate	None
PA	B5P	Decongestant-Analgesic, Salicylate-Expectorant Combination	None
PA	B5Q	Non-narcotic Antitussive-1st Generation Antihistamine-Decongestant-Analgesic, Salicylate Combination	None
PA	B5S	1st Generation Antihistamine-Analgesic, Non-salicylate Combination	None
PA	B5T	1st Generation Antihistamine-Anticholinergic Combination	None
PA	B5Y	Analgesic, Non-Salicylate – 1st Generation Antihistamine - Xanthine	None
D	B6D	Decongestant-Expectorant with Zinc Combination	None

Electrolyte Balancing Sys/Metabolic Sys/Nutrition

Status	TCC	Description	Preferred Drug(s)
PA	C0B	Water	None
D	C0C	Drugs Used To Treat Acidosis	None
PA	C0D	Antialcoholic Preparations	None
PA	C0K	Bicarbonate Producing/Containing Agents	None
PA	C1A	Electrolyte Depleters	None
PA	C1B	Sodium Replacement	None
PA	C1D	Potassium Replacement	None
PA	C1F	Calcium Replacement	None
PA	C1H	Magnesium Replacement	None
D	C1K	Cardioplegic Solutions	None
PA	C1P	Phosphate Replacement	None
PA	C1W	Electrolyte Replacement	None
D	C2H	Respiratory Gases	None
PA	C3B	Iron Replacement	None
PA	C3C	Zinc Replacement	None
PA	C3H	Iodine Replacement	None
PA	C3M	Miscellaneous Mineral Replacement	None

Status	TCC	Description	Preferred Drug(s)
PA	C4F	Antihyperglycemic, (DPP-4) Enzyme Inhibitor & Biguanide Type (N-S) Combination	None
PA	C4G	Insulins	None
PA	C4J	Antihyperglycemic, DPP-4 Inhibitors	None
PA	C4K	Hypoglycemics, Insulin-Release Stim. Type	None
PA	C4L	Hypoglycemics, Biguanide Type (N-S)	None
PA	C4M	Hypoglycemics, Alpha-Glucosidase Inhibitor Type (N-S)	None
PA	C4N	Hypoglycemics, Insulin-Response Enhancer (N-S)	None
PA	C4Q	Hypoglycemics, Combination	None
PA	C4R	Hypoglycemics, Insulin-Response & Insulin Release Combinations	None
PA	C4S	Hypoglycemics, Insulin-Release Stimulant & Biguanide (N-S) Combinations	None
PA	C4T	Hypoglycemics, Insulin-Response Enhancer & Biguanide Type (N-S) Combinations	None
D	C4U	Hypoglycemics, Biguanide Type & Dietary Supplement Combinations	None
PA	C5A	Carbohydrates	None
PA	C5B	Protein Replacement	None
D	C5C	Infant Formulas	None
D	C5D	Diet Foods	None
D	C5F	Miscellaneous Food Supplements	None
D	C5G	Food Oils	None
PA	C5J	IV Solutions: Dextrose/Water	None
PA	C5K	IV Solutions: Dextrose/Saline	None
PA	C5L	IV Solutions: Dextrose/Ringers	None
PA	C5M	IV Solutions: Dextrose/Lactated Ringers	None
PA	C5O	Solutions, Miscellaneous	None
D	C5X	Nutritional Therapy, Phenylketonuria (PKU) Formulation	None
D	C5U	Nutritional Therapy, Glucose Intolerance Formulation	None
D	C6A	Vitamin A Preparations	None
D	C6B	Vitamin B Preparations	None
PA	C6C	Vitamin C Preparations	None
D	C6D	Vitamin D Preparations	None
D	C6E	Vitamin E Preparations	None
D	C6F	Prenatal Vitamin Preparations	None
D	C6G	Geriatric Vitamin Preparations	None
D	C6H	Pediatric Vitamin Preparations	None

Status	TCC	Description	Preferred Drug(s)
D	C6I	Antioxidant Multivitamin Combinations	None
D	C6J	Bioflavonoids	None
PA	C6K	Vitamin K Preparations	None
PA	C6L	Vitamin B12 Preparations	None
PA	C6M	Folic Acid Preparations	None
D	C6N	Niacin Preparations	None
D	C6P	Panthenol Preparations	None
D	C6Q	Vitamin B6 Preparations	None
D	C6R	Vitamin B2 Preparations	None
D	C6T	Vitamin B1 Preparations	None
D	C6Z	Miscellaneous Multivitamin Preparations	None
D	C7A	Purine Inhibitors	None
D	C7D	Metabolic Deficiency Agents	None
PA	C7F	Appetite Stimulants for Anorexia, Cachexia, Wasting Syndrome	None
D	C7G	Hyperuricemia Treatments – Urate-Oxidase Enzyme-Type	None
A	C8A	Metallic Poison Antidotes	All
A	C8B	Acid And Alkali Poison Antidotes	All
A	C8E	Miscellaneous Antidotes	All

Biliary System/Gastro-Intestinal System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	D0U	Gastrointestinal Radiopaque Diagnostics	None
PA	D1D	Dental Aids & Preparations	None
PA	D1E	Periodontal Tetracycline Anti-infective, Local	None
D	D2A	Fluoride Preparations	None
D	D2D	Tooth Ache Preparations	None
A	D4A	Acid Replacement	All
A	D4B	Antacids	Sodium Bicarbonate (generics only) Aluminum Hydroxide (generics only) Antacid/Simethicone (generics only) Calcium Carbonate (generics only)
A	D4D	Antidiarrheal Microorganisms Agents	All
A	D4E	Antiulcer Preparations	Misoprostol (generics only) Sucralfate (generics only)
D	D4F	Antiulcer -- H. Pylori Agents	None
PA	D4G	Gastric Enzymes	None
PA	D4H	Oral Mucositis/Stomatitis Agents	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	D4I	Oral Mucositis/Stomatitis Antiinflammatory Agents	None
PA	D4N	Antiflatulents	None
D	D4O	Gastrointestinal Ultrasound Image Enhancing Adjunct, Diag	None
PA	D4Q	Digestive Agents, Other	None
A	D4R	Saliva Stimulant Agents	All
A	D5P	Intestinal Adsorbents And Protectives	All
PA	D6A	Drugs To Treat Chronic Inflammatory Diseases Of The Colon	None
D	D6C	Irritable Bowel Syndrome Agent, 5HT-3 Antagonist-Type	None
PA	D6D	Antidiarrheals	None
D	D6E	Irritable Bowel Syndrome Agents, 5HT-4 Partial Agonist	None
PA	D6F	Drugs To Treat Chronic Inflammatory Colon Dx 5 – Aminosalicyl	None
A	D6H	Hemorrhoidal Agents	All
A	D6S	Laxatives And Cathartics	Docusate (generics only) Lactulose (generics only) Polyethylene glycol (generics only) Psyllium (generics only)
PA	D7A	Bile Salts	None
PA	D7B	Choleretics	None
D	D7C	Hepatic Diagnostics	None
D	D7D	Drugs To Treat Hereditary Tyrosinemia	None
PA	D7J	Hepatic Dysfunction Preventive/ Therapy Agents	None
A	D7L	Bile Salt Inhibitors	None
D	D7T	Biliary Diagnostics	None
D	D7U	Biliary Diagnostics, Radiopaque	None
PA	D8A	Pancreatic Enzymes	None
PA	D9A	Ammonia Inhibitors	None

Male Genital System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	F1A	Androgenic Agents	None
PA	F2A	Drugs To Treat Impotency	None

Female Genital System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	G0U	Uterine Radiopaque Diagnostic Agents	None
D	G1A	Estrogenic Agents	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	G1B	Estrogen/Androgen Combination Preparations	None
D	G2A	Progestational Agents	None
D	G3A	Oxytocics	None
D	G8A	Contraceptives, Oral	None
D	G8B	Contraceptives, Implantable	None
D	G8C	Contraceptives, Injectable	None
PA	G8D	Abortifacient, Progesterone Receptor Antagonist Type	None
D	G8F	Contraceptives, Transdermal	None
D	G9A	Contraceptives, Intravaginal	None
D	G9B	Contraceptives, Intravaginal, Systemic	None

Nervous System (Except Autonomic)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	H0A	Local Anesthetics	Cepacol
D	H0E	Agents To Treat Multiple Sclerosis	None
D	H0F	Agents To Treat Neuromusc Transmission Dis, Potassium Channel Blocker Type	None
D	H0G	Fibromyalgia Agents, Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	None
D	H1A	Alzheimer's Tx, N-Methyl-D-Aspart (NMDA) Recept Antags	None
D	H1U	Cerebral Spinal Radiopaque Diagnostics	None
PA	H2A	Central Nervous System Stimulants	None
D	H2B	General Anesthetics, Inhalant	None
D	H2C	General Anesthetics, Injectable	None
A	H2D	Barbiturates (Phenobarbital Only)	Phenobarbital (generics only)
A	H2E	Non-Barbiturate, Sedative-Hypnotics *****Acute use only*****	Chloral Hydrate (generics only) Estazolam (generics only) Diphenhydramine (generics only) Flurazepam (generics only) Temazepam (generics only) Triazolam (generics only)
		Benzodiazepines & Others	
A	H2F	Antianxiety Drugs	Alprazolam/ER (generics only) Buspirone (generics only) Chlordiazepoxide Clorazepate Dipotassium (generics only) Diazepam (generics only) Lorazepam (generics only) Oxazepam (generics only)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	H2G	Anti-Psychotics, Phenothiazines	Chlorpromazine (generics only) Fluphenazine (generics only) Perphenazine (generics only) Thioridazine (generics only) Trifluoperazinel (generics only)
A	H2H	Monoamine Oxidase (MAO) Inhibitors	Phenelzine (generics only) Tranylcypromine (generics only) Isocarboxazid (generics only)
A	H2M	Anti-Mania Drugs	Lithium Carbonate/CR (generics only) Lithium Citrate (generics only)
D	H2T	Alcohol-Systemic Use	None
A	H2U	Tricyclic Antidepressants & Related Non-SRI	Amitriptyline (generics only) Desipramine (generics only) Doxepin (generics only) Imipramine (generics only) Maprotiline (generics only) Nortriptyline (generics only)
PA	H2V	Anti-Narcolepsy/Anti-Hyperkinesis Agents	None
A	H2W	Tricyclic Antidepressant/Phenothiazine Combinations	Amitriptyline/Perphenazine (generics only)
PA	H2X	Tricyclic Antidepressant/Benzodiazepine Combination	None
A	H3A	Analgesics, Narcotics	
		Short Acting Opioids ****Effective January 1, 2011**	Codeine sulfate/phosphate (generics only) Hydrocodone/Acetaminophen (generics only) Hydromorphone (generics only) Meperidine (generics only) Morphine sulfate (generics only) Oxycodone (generics only) Oxycodone/Acetaminophen (generics only) Oxycodone/Aspirin (generics only) Pentazocine/Naloxone (generics only) Pentazocine/Acetaminophen (generics only) Tramadol/ER (generics only) Tramadol/Acetaminophen (generics only)
A	H3C	Analgesics, Non-Narcotics	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	H3D	Salicylate Analgesics	Aspirin (generics only) Aspirin Buffered (generics only) Choline Mag Trisalicylate (generics only) Diflunisal (generics only) Salsalate (generics only)
A	H3E	Analgesic/Antipyretics, Non-Salicylate	Acetaminophen (generics only)
PA	H3F	Antimigraine Preparations	None
D	H3H	Analgesics Narcotic, Anesthetic Adjunct	None
D	H3I	Analgesics, Neuronal-type Calcium Channel Blocker	None
D	H3J	Analgesics Narcotic/Dietary Supplement Combinations	None
A	H3K	Analgesics, Non-salicylate and Barbiturate Combination	Acetaminophen/Butalbital (generics only)
A	H3L	Analgesics, Non-salicylate, Barbiturate and Xanthine Combination	Acetaminophen/Caffeine/Butal bital (generics only)
PA	H3M	Narcotic Analgesic, Non-salicylate Analgesic, Barbiturate and Xanthine Combination	None
A	H3N	Analgesics, Narcotics Agonist and NSAIDs, COX Inhibitor-type Combination	Hydrocodone/Ibuprofen (generics only)
A	H3O	Analgesics, Salicylate, Barbiturate and Xanthine Combination	Aspirin/Caffeine/Butalbital (generics only)
PA	H3R	Narcotic and Salicylate Analgesics, Barbiturate and Xanthine Combination	None
A	H3T	Narcotic Antagonists	Naloxone (generics only)
A	H3U	Narcotic Analgesic and Non-salicylate Analgesic Combination	Codeine/Acetaminophen (generics only)
A	H3V	Analgesics, Salicylate & Non-salicylate Combination	All
A	H3X	Narcotic Analgesic & Salicylate Analgesic Combination	Aspirin/Codeine phosphate (generics only)
PA	H3Y	Mu-Opioid Receptor Antagonists, Peripherally-Acting	None
A	H4B	Anticonvulsants ****Please see PB 05-10 Antiepileptic Drugs Guideline for Chronic Pain****	Carbamazepine/XR (generics only) Clonazepam (generics only) Depakote (generics only) Diazepam (generics only) Mephobarbital (generics only) Gabapentin (generics only) Phenytoin Sodium ER (generics only) Primidone (generics only) Valproic Acid (generics only)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	H4D	Anticonvulsant/Dietary Supplement Combinations	None
PA	H6A	Antiparkinsonism Drugs, Other	None
PA	H6B	Antiparkinsonism Drugs, Anticholinergic	None
A	H6C	Antitussive, Non-Narcotic	Benzonatate (generics only) Dextromethorphan (generics only)
A	H6E	Emetics	Ipecac (generics only)
D	H6F	Skeletal Muscle Relaxants/Dietary Supplement Combinations	None
PA	H6G	Skeletal Muscle Relaxant & Topical Irritant Counter-Irritant Combinations	None
	A	Anti-Emetics	Dimenhydrinate (generics only) Emetrol Meclizine (generics only) Prochlorperazine (generics only) Promethazine (generics only) Thiethylperazine (generics only) Trimethobenzamide (generics only) ****5HT3 products require prior authorization****
D	H6L	Movement Disorders (Drug Therapy)	None
A	H7E	Serotonin-2 Antagonist/Reuptake Inhib (SARIs)	Trazodone (generics only)
A	H7J	MAOIs - Non-Selective & Irreversible	All
PA	H7N	Smoking Deterrents, Others	None
A	H7O	Antipsychotic, Dopamine Antagonist, Butyrophenones	All
A	H7P	Antipsychotic, Dopamine Antagonist, Thioxanthenes	Thiothixene (generics only)
A	H7R	Antipsychotic, Dopamine Antagonist, Diphenylbutylpiperidines	Pimozide (Orap)
A	H7S	Antipsychotic, Dopamine And Serotonin Antagonist	Molidone (Moban)
A	H7U	Antipsychotic, Dopamine And Serotonin Antagonist	Loxapine Succinate
D	H7W	Anti-Narcolepsy/Anti-Cataplexy, Sedative-Type Agent	None
PA	H7Y	Tx For Attn Deficit-Hyperactivity Disorder (ADHD), NRI-Type	None
PA	H7Z	SSRI & Antipsych, Atyp, Dopamine & Serotonin Antagonist Combination	None
PA	H8A	Antianxiety, Antispasmodic Combination	None
A	H8B	Hypnotic, Melatonin MT1/MT2 Receptor Agonists	Ramelteon (Rozerem)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	H8I	Selective Serotonin Reuptake Inhibitor (SSRI)/Dietary Supplement Combinations	None
D	H8J	Norepinephrine and Dopamine Reuptake Inhibitor (NDRI)/Dietary Supplement Combinations	None
D	H8K	Antianxiety Drug/Dietary Supplement Combinations	None
D	H8M	Tx for ADHD – Selective Alpha 2A-Adrenergic Receptor Agonist	None

Autonomic Nervous System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	J1A	Parasympathetic Agents	Bethanechol chloride (generics only) Pilocarpine (generics only)
PA	J1B	Cholinesterase Inhibitors	None
PA	J2A	Belladonna Alkaloids	None
PA	J2B	Anticholinergics, Quaternary	None
A	J2D	Anticholinergics/Antispasmodics	Dicyclomine (generics only)
PA	J3A	Smoking Deterrent Agents-Ganglionic Stimulant	None
PA	J3C	Smoking Deterrent-Nicotinic Receptor Partial Agonist	None
D	J5A	Adrenergic Agents, Catecholamines	None
D	J5B	Adrenergics, Aromatic Non-Catecholamines (Amphetamine)	None
A	J5C	Adrenergic Agents, Non-Aromatic	All
A	J5D	Beta-Adrenergic Agents	
		Oral Beta Agonist	Albuterol sulfate/SA (generics only) Metaproterenol (generics only)
A	J5E	Sympathomimetic Nasal Decongestants	Oxymetazoline/Methol (Afrin) Ephedrine Sulfate (generics only) Pseudoephedrine (generics only)
A	J5F	Anaphylaxis Therapy Agents	Ana-Kit Epipen
A	J5H	Adrenergic Vasopressor Agents	Midodrine HCl
A	J5J	Beta Adrenergic and Anticholinergic Combination	Albuterol/Ipratropium MDI/Nebulizer Solution
PA	J7A	Alpha/Beta Adrenergic Blocking Agents	None
A	J7B	Alpha-Adrenergic Blocking Agents	Doxazosin Mesylate Prazosin Terazosin

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	J7C	Beta-Adrenergic Blocking Agents	None
PA	J7E	Alpha-Adrenergic Blocking Agent/ Thiazide Combination	None
D	J7G	Beta Adrenergic Agent/Dietary Supplement Combinations	None
D	J8A	Anorexic Agents	None
D	J8B	Cannabinoid-1 Receptor (CB1) Antagonist	None
A	J9A	Intestinal Motility Stimulants	Metoclopramide (generics only)
PA	J9B	Antispasmodic Agents	None

Skin/Subcutaneous Tissue

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	L0B	Topical/Mucous Membrane/Sub-Q Enzyme Preps	Collagenase (Santyl)
PA	L1A	Antipsoriatic Agents, Systemic	None
D	L1B	Acne Agents, Systemic	None
A	L2A	Emollients	All
A	L3A	Protectives	All
A	L3P	Antipruritics, Topical	Calamine/Pamoxine (Caladryl) Diphenhydramine (generics only)
A	L4A	Astringents	All
D	L5A	Keratolytics	None
D	L5B	Sunscreens	None
D	L5C	Abrasives	None
D	L5E	Antiseborrheic Agents	None
PA	L5F	Antipsoriatic Agents, Topical	None
D	L5G	Rosacea Agents, Topical	None
D	L5H	Acne Agents, Topical	None
A	L5I	Wound Healing Agents, Local	Hyalofill-F Peviderm Wound Care Solution
A	L6A	Irritants/Counter-Irritants	All
D	L7A	Shampoos	None
D	L8A	Deodorants	None
D	L8B	Antiperspirants	None
A	L9A	Miscellaneous Topical Agents	All
D	L9B	Vitamin A Derivatives	None
D	L9C	Hypopigmentation Agents	None
D	L9D	Topical Hyperpigmentation Agents	None
D	L9F	Cosmetic/Skin Coloring/Dye Agents, Topical	None
D	L9G	Skin Tissue Replacement	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	L9I	Vitamin A Derivatives, Topical Cosmetic Agents	None

Blood

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	M0B	Plasma Proteins	None
PA	M0D	Plasma Expanders	None
PA	M0E	Antihemophilic Factors	None
PA	M0F	Factor IX Preparations	None
D	M0L	Human Monoclonal Antibody Complement (C5) Inhibitors	None
PA	M0M	Protein C Preparations	None
A	M3A	Occult Blood Tests	All
PA	M4A	Blood Sugar Diagnostics	None
PA	M4B	IV Fat Emulsions	None
D	M4E	Lipotropics	None
D	M4G	Hyperglycemics	None
D	M4I	Antihyperlipid (HMG CoA) & Calcium Channel Blocker	None
PA	M9A	Topical Hemostatics	None
PA	M9D	Antifibrinolytic Agents	None
PA	M9E	Thrombin Inhibitors, Hirudin Type Agents	None
PA	M9F	Thrombolytic Enzymes	None
PA	M9J	Citrates As Anticoagulants	None
PA	M9K	Heparin Preparations	None
A	M9L	Oral Anticoagulants, Coumarin Type	Warfarin sodium (generics only)
PA	M9P	Platelet Aggregation Inhibitors	None

Bone Marrow

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	N1B	Hematinics, Other	None
D	N1C	Leukocyte (WBC) Stimulants	None
PA	N1D	Platelet Reducing Agents	None
PA	N1E	Platelet Proliferation Stimulants	None
PA	N1G	CXCR4 Chemokine Receptor Antagonists	None

Endocrine System (Except Gonads)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	P0B	Follicle Stimulating Hormones	None
D	P1A	Growth Hormones	None
D	P1B	Somatostatic Agents	None
D	P1E	Adrenocorticotrophic Hormones	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	P1F	Pituitary Suppressive Agents	None
D	P1H	Growth Hormone Releasing Hormone	None
D	P1L	Luteinizing Hormone Releasing-Hormone	None
D	P1M	LHRH/GNRH Agonist Analog Pituitary Suppressants	None
D	P1N	LHRH Antagonist Pituitary Suppressant Agents	None
D	P1P	LHRH/GNRH Agonist Pituitary Suppressants-C Prec Puberty	None
D	P1Q	Growth Hormone Receptor Antagonists	None
D	P1U	Metabolic Function Diagnostics	None
D	P2B	Antidiuretic And Vasopressor Hormones	None
D	P3A	Thyroid Hormones	None
D	P3B	Thyroid Function Diagnostic Agents	None
D	P3L	Antithyroid Preparations	None
D	P4B	Bone Formation Stimulating Agents – Parathyroid Hormone	None
D	P4D	Hyperparathyroid Treatment Agents – Vitamin D Analog-Type	None
PA	P4E	Bone Morphogenic Agents	None
PA	P4L	Bone Resorption Suppression Agents	None
D	P4M	Calcimimetic, Parathyroid Calcium Enhancer	None
A	P5A	Glucocorticoids	
		Oral Corticosteroids	Betamethasone (generics only) Cortisone Acetate (generics only) Dexamethasone (generics only) Hydrocortisone (generics only) Methylprednisolone (generics only) Prednisolone (generics only) Prednisone (generics only)
A	P5S	Mineralocorticoids	None
D	P6A	Pineal Hormone Agents	None

Ear, Eye, Nose, Rectum, Topical, Vagina, Spec Senses

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	Q2D	Ophth Vascular Endothelial Growth Factor Antagonist	None
D	Q2U	Eye Diagnostic Agents	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	Q3A	Rectal Preparations	Hydrocortisone acetate (generics only) Hydrocortisone/Pramoxine (Proctofoam-HC)
A	Q3B	Rectal/Lower Bowel Prep, Glucocorticoid, Non-Hemorrhoidal	All
A	Q3D	Hemorrhoidal Preparations	Benzocaine/Benzethonium (Americaine Hemorrhoidal) Hydrocortisone/Pamoxine (Analpram-HC) Phenylephrine (generics only) Hydrocortisone acetate (Anusol HC) Pramoxine (Tronolane)
PA	Q3E	Chronic Inflm Colon Dx 5 - Aminosalicylates	None
A	Q3H	Hemorrhoidal Preparations, Local Anesthetics	Dibucaine (generics only)
A	Q3I	Hemorrhoidal Preparations, Antiinflammatory Steroid/Local Anesthetics	All
A	Q3S	Laxatives, Local/Rectal	All
PA	Q4A	Vaginal Preparations	None
PA	Q4B	Vaginal Antiseptics	None
PA	Q4F	Vaginal Antifungals	None
PA	Q4H	Vaginal/Cervical Care and Treatment Agents	None
D	Q4K	Vaginal Estrogen Preparations	None
PA	Q4S	Vaginal Sulfonamides	None
PA	Q4W	Vaginal Antibiotics	None
D	Q5A	Topical Preparations, Miscellaneous	None
A	Q5B	Topical Preparations, Antibacterials	Betadine (generics only) Boric Acid (generics only) Cetaphil Chlorhexidine Gluconate (generics only) Clioquinol/Hydrocortisone (generics only) Iodochlorhydroxyquin/HC (generics only) Povidone-Iodine (generics only) Silver Nitrate (generics only) Zephiran Chloride (generics only)
D	Q5C	Topical Preparations, Hypertrichotic Agents	None
PA	Q5E	Topical Antiinflammatory, Non-Steroidal	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	Q5F	Topical Antifungals	None
A	Q5H	Topical Local Anesthetics	Benzocaine (generics only) Cetacaine (generics only) Dibucaine (generics only) Ethyl Chloride (generics only) Lidocaine (**NOT Lidoderm**) Pramoxine (generics only) Benzocaine/Triclosan (generics only) Benzocaine/Resorcinal (generics only)
PA	Q5K	Topical Immunosuppressive Agents	None
PA	Q5N	Topical Antineoplastics	None
A	Q5P	Topical Antiinflammatory Preparations	Amcinonide (generics only) Betamethasone dipropionate (generics only) Betamethasone valerate (generics only) Clobetasol propionate (generics only) Desonide (generics only) Desoximetasone (generics only) Diflorasone diacetate (generics only) Triamcinolone acetonide (generics only) Embeline (generics only) Fluocinolone acetonide (generics only) Fluocinonide (generics only) Hydrocortisone (generics only) Mometasone furoate (generics only)
A	Q5R	Topical Antiparasitics	Cromtamiton (Eurax) Permethrin (generics only)
A	Q5S	Topical Sulfonamides	Silver sulfadiazine (generics only) Sodium sulfacetamide/Sulfur (generics only)
PA	Q5V	Topical Antivirals	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	Q5W	Topical Antibiotics *****Effective January 1, 2011*****	Bacitracin (generics only) Bacitracin/Polymyxin B (generics only) Gentamicin sulfate (generics only) Mupirocin (generics only) Neomycin/Bacitracin/Polymyxin B (generics only) Neomycin/Bacitracin/Polymyxin B/Pramoxine (generics only) Neomycin/Polymyxin B/Pramoxine (generics only)
A	Q5X	Topical Antibiotics/Antiinflammatory, Steroidal	Neomycin/Hydrocortisone (generics only)
A	Q6A	Eye Preparations, Miscellaneous	All
A	Q6C	Eye Vasoconstrictors (Rx Only)	All
A	Q6D	Eye Vasoconstrictors (OTC Only)	All
A	Q6E	Eye Irrigations	All
A	Q6G	Miotics And Other Intraocular Pressure Reducers	Brinzolamide (Azopt) Betaxolol (generics only) Brimonidine tartrate (generics only) Carteolol (generics only) Timolol/Dorzolamide (Cosopt) Carbachol (generics only) Levobunolol (generics only) Metipranolol (generics only) P1E1 P2E1 P4E1 P6E1 Phospholine iodide (generics only) Pilocarpine (generics only) Timolol maleate (generics only) Dorzolamide (Trusopt) Latanoprost (Xalatan)
A	Q6H	Eye Local Anesthetics	None
A	Q6I	Eye Antibiotic-Corticoid Combinations	All
PA	Q6J	Mydriatics	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	Q6P	Eye Antiinflammatory Agents	Dexamethasone sod phosphate (generics only) Diclofenac sodium (generics only) Fluorometholone (generics only) Flurbiprofen sodium (generics only) HMS Loteprednol (Lotemax) Prednisolone acetate (generics only)
A	Q6R	Eye Antihistamines	Levocarbastine (Livostin) Olopatadine (Patanol) Ketotifen (Zaditor)
A	Q6S	Eye Sulfonamides	Sulfacetamide sodium (generics only) Sulfacetamide/Prednisolone (generics only)
A	Q6T	Artificial Tears	All
PA	Q6U	Ophthalmic Mast Cell Stabilizers	None
PA	Q6V	Eye Antivirals	None
A	Q6W	Eye Antibiotics	Bacitracin (generics only) Bacitracin/Polymyxin (generics only) Chloramphenicol (generics only) Ciprofloxacin (generics only) Erythromycin (generics only) Gatifloxacin (Zymar) Gentamicin sulfate (generics only) Neomycin/Bacitracin/Polymyxin (generics only) Ofloxacin (generics only) Polymyxin B sulfate/Trimethoprim (generics only) Tobramycin sulfate (generics only)
A	Q6Y	Eye Preparations, Miscellaneous (OTC Only)	All
A	Q7A	Nose Preparations, Miscellaneous (Rx Only)	Ipratropium bromide (generics only)
A	Q7C	Nose Preparations, Vasoconstrictors (Rx Only)	All
A	Q7D	Nose Preparations, Vasoconstrictors (OTC Only)	All
PA	Q7E	Nasal Antihistamine	None
PA	Q7H	Nasal Mast Cell Stabilizer Agents	None
A	Q7W	Nose Preparations, Antibiotics	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	Q7Y	Nose Preparations, Miscellaneous (Otc Only)	All
A	Q8B	Ear Preparations, Miscellaneous Antiinfectives	Acetasol (generics only) Acetic acid (generics only) Acetic acid/Hydrocortisone (generics only)
PA	Q8C	Otic, Antiinfective-Local Anesthetic Combinations	None
A	Q8F	Ear Preparations, Anti-Inflammatory-Antibiotics	Ciprofloxacin/Hydrocortisone (Cipro HC)
PA	Q8H	Ear Preparations, Local Anesthetics	None
D	Q8R	Ear Preparations, Ear Wax Removers	None
A	Q8W	Ear Preparations, Antibiotics	Neomycin/Polymyxin/HC (generics only)
PA	Q8Y	Ear Preparations, Miscellaneous (OTC Only)	None
D	Q9B	Benign Prostatic Hypertrophy/ Micturition Agents	None

Kidney/Urinary Tract

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	R1B	Osmotic Diuretics	None
PA	R1E	Carbonic Anhydrase Inhibitors	None
PA	R1F	Thiazide Diuretics And Related Agents	None
PA	R1H	Potassium Sparing Diuretics	None
PA	R1K	Miscellaneous Diuretics	None
PA	R1L	Potassium Sparing Diuretics In Combination	None
PA	R1M	Loop Diuretics	None
PA	R1N	Arginine Vasopressin (AVP) Receptor Antagonists	None
D	R1R	Uricosuric Agents	None
A	R1S	Urinary Ph Modifiers	Potassium citrate/Sodium citrate (Citrolith) Potassium phosphate monobasic (K-Phos Original) Potassium citrate/Citric acid (generics only) Renacidin Sodium citrate & Citric acid (generics only) Potassium citrate (Urocit-K)
D	R1U	Renal Function Diagnostic Agents	None
D	R2U	Urinary Tract Radiopaque Diagnostics	None
PA	R3D	Drug Detection Tests, Urine	None
PA	R3U	Urine Glucose Test Aids	None
PA	R3V	Miscellaneous Urine Test Aids	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	R3W	Urine Acetone Test Aids	None
PA	R3Y	Urine Multiple Test Aids	None
PA	R4A	Kidney Stone Agents	None
PA	R5A	Urinary Tract Anesthetic/Analgesic Agents	None

Locomotor System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	S2A	Colchicine	None
PA	S2C	Gold Salts	None
PA	S2H	Anti-Inflammatory/Antiarthritic Agents, Miscellaneous	None
PA	S2I	Anti-Inflammatory, Pyrimidine Synthesis Inhibitor	None
PA	S2J	Anti-Inflammatory, Tumor Necrosis Factor Inhibitor	None
PA	S2P	NSAIDs, Cyclooxygenase 2 Inhibitor-Type & Proton Pump Inhib Comb	None
PA	S2Q	Anti-inflammatory, Selective Costim. Mod., T-Cell Inhibitors	None
D	S2R	NSAIDs (Nonsteroidal Anti-inflammatory Drugs) Cyclooxygenase Inhibitor/Dietary Supplement Combination	None
D	S2S	Analgesic, NSAID COX Type-1st Generation Antihistamine, Sedative Combination	None
PA	S2T	NSAIDs (COX Non-Specific Inhibitor) & Prostaglandin Combination	None
PA	S2U	NSAIDs, COX Non-Selective & Topical Irritant Counter-Irritant Combinations	None
D	S7A	Neuromuscular Blocking Agents	None

Ear, Eye, Nose, Rectum, Topical, Vagina, Spec Senses (CONT.)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	T0A	Topical Vit D Analog/Antiinflammatory Steroidal	None
PA	T0B	Topical Pleuromutilin Derivatives	None
D	T0C	Topical Genital Wart-HPV Treatment Agent	None

Miscellaneous Drugs and Pharmaceutical Adjuvants

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	U5A	Homeopathic Drugs	None
D	U5B	Herbal Drugs	None
D	U5F	Animal/Human Derived Agents	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	U6A	Pharmaceutical Adjuvants, Tableting Agents	All
A	U6B	Pharmaceutical Adjuvants, Coating Agents	All
A	U6C	Thickening Agents	All
A	U6F	Hydrophilic Cream/Ointment Bases	All
A	U6H	Solvents	All
A	U6N	Vehicles	All
A	U6S	Propellants	All
PA	U6W	Bulk Chemicals, O.U.	None
A	U7A	Suspending Agents	All
A	U7D	Surfactants	All
A	U7H	Antioxidants	All
A	U7K	Flavoring Agents	All
A	U7N	Sweeteners	All
A	U7P	Perfumes	All
A	U7Q	Coloring Agents	All

Neoplasms

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	V1A	Alkylating Agents	None
PA	V1B	Antimetabolites	None
PA	V1C	Vinca Alkaloids	None
PA	V1D	Antibiotic Antineoplastics	None
PA	V1E	Steroid Antineoplastics	None
PA	V1F	Miscellaneous Antineoplastics	None
PA	V1I	Chemotherapy Antidotes	None
PA	V1J	Antiandrogenic Agents	None
PA	V1K	Antineoplastics Antibody/Antibody-Drug Complexes	None
PA	V1M	Antineoplastics Immunomodulator Agents	None
D	V1O	Antineoplastic Lhrh Agonists, Pituitary Suppressant	None
PA	V1Q	Antineoplastic Systemic Enzyme Inhibitor	None
PA	V1R	Photoactivated, Antineoplastic Agents, Systemic	None
PA	V1T	Selective Estrogen Receptor Modulators (Serm)	None
D	V1V	Antineoplastic LHRH (GNRH) Antagonist, Pituitary Suppressors	None
PA	V1W	Antineoplastic EGF Receptor Blocker RCMB MC Antibody	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	V1X	Antineoplastic Hum VEGF Inhibitor RCMB MC Antibody	None
PA	V3A	Antineoplastic Histone Deacetylase Inhibitors (HDIs, HDACIs)	None
PA	V3C	Antineoplastic – MTOR Kinase Inhibitors	None
PA	V3D	Antineoplastic – Epothilones and Analogs	None
PA	V3E	Antineoplastic – Topoisomerase 1 Inhibitors	None

Anti-Infecting Agents

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	W1A	Penicillins	Amoxicillin trihydrate/Potassium Claulanate (generics only) Amoxicillin (generics only) Ampicillin (generics only) Dicloxacillin sodium (generics only) Penicillin V potassium (generics only)
A	W1C	Tetracyclines	Doxycycline (generics only) Minocycline (generics only) Tetracycline (generics only)
A	W1E	Chloramphenicol and Derivatives	All
A	W1F	Aminoglycosides	All
A	W1G	Antitubercular Antibiotics	Rifampin (generics only)
A	W1J	Vancomycin And Derivatives	Vancomycin oral
A	W1K	Lincosamides	Clindamycin (generics only) Lincomycin (generics only)
A	W1L	Topical Antibiotics	All
A	W1M	Streptogramins	All
A	W1N	Polymyxin And Derivatives	Colistimethate sodium (generics only) Polymyxin B sulfate (generics only)
A	W1O	Oxazolidones	Linezolid (Zyvox)
A	W1P	Oxabeta-Lactams	All
A	W1Q	Quinolones	Moxifloxacin (Avelox) Ciprofloxacin (generics only) Levofloxacin (Levaquin) Ofloxacin (generics only) Gatifloxacin (Tequin)
A	W1S	Carbapenems (Thienamycins)	All
A	W1W	Cephalosporins-1st Generation	Cefadroxil (generics only) Cephalexin (generics only)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	W1X	Cephalosporins-2nd Generation	Cefaclor (generics only) Cefuroxime axetil (generics only) Cefprozil (Cefzil)
A	W1Y	Cephalosporins-3rd Generation	Cefixime (Suprax) Cefditoren (Spectracef)
A	W1Z	Cephalosporins-4th Generation	All
A	W2A	Absorbable Sulfonamides	Sulfadiazine (generics only) Sulfamethoxazole/Trimethoprim (generics only) Sulfisoxazole (generics only)
A	W2E	Antitubercular Agents	Ethambutol (generics only) Isoniazid (generics only) Pyrazinamide (generics only)
A	W2F	Nitrofuran Derivatives	Nitrofurantoin macrocrystal (generics only) Nitrofurantoin (generics only)
A	W2G	Antibacterial Chemotherapeutic Agents, Misc.	Methenamine mandelate (generics only) Trimethoprim (generics only) Urinary antiseptic (generics only)
A	W2Y	Miscellaneous Antiinfectives	All
A	W3A	Antifungal Antibiotics	Griseofluvin ultramicroside (generics only) Nystatin (generics only)
A	W3B	Antifungal Agents	Ketoconazole (generics only) Clotrimazole (generics only) Fluconazole (generics only) Terbinafine (Lamisil) Itraconazole (generics only) Voriconazole (Vfend)
A	W4A	Antimalarial Drugs	Chloroquine phosphate (generics only) Pyrimethamine (Daraprim) Pyrimethamine/Sulfadoxine (Fansidar) Halofantrine (Halfan) Hydroxychloroquine sulfate (generics only) Atovaquone/Proguanil (Malarone) Mefloquine (generics only) Primaquine (generics only) Quinine sulfate (generics only)
D	W4C	Amebacides	None
A	W4E	Trichomonacides	Metronidazole (generics only)
D	W4K	Miscellaneous Antiprotozoal Drugs	None
D	W4L	Anthelmintics	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	W4M	Topical Antiparasitics	None
D	W4P	Antileprotics	None
D	W4Q	Insecticides	None
PA	W5A	Antivirals	None
A	W5C	Antivirals, HIV-Specific, Protease Inhibitors	All
PA	W5D	Antiviral Monoclonal Antibodies	None
PA	W5E	Hepatitis A Treatment Agents	None
PA	W5F	Hepatitis B Treatment Agents	None
PA	W5G	Hepatitis C Treatment Agents	None
A	W5I	Antivirals, HIV-Spec, Nucleotide Analog, RTIs	All
A	W5J	Antivirals, HIV-Spec, Nucleoside Analog, RTIs	All
A	W5K	Antivirals, HIV-Spec, Non-Nucleoside RTIs	All
A	W5L	Antivirals, HIV-Spec, Nucleoside Analog, RTI Combinations	All
A	W5M	Antivirals, HIV-Specific, Protease Inhibitor Combinations	All
A	W5O	Antivirals, HIV-Specific, Nucleoside-Nucleotide Analog	All
A	W5Q	ARTV Comb – Nucleoside-Nucleotide Analog & Non-nucleoside RTIS	All
D	W5S	Antivirals, General/Dietary Supplement Combinations	None
A	W5U	Antivirals, HIV-1 Integrase Strand Transfer Inhibitor	All
D	W6A	Drugs To Treat Sepsis Syndrome, Non-Antibiotic	None
D	W7B	Viral/Tumorigenic Vaccines	None
D	W7C	Influenza Virus Vaccines	None
D	W7J	Arthropod-Borne And Other Neurotoxic Virus Vaccines	None
D	W7K	Antisera ****Effective January 1, 2011**	None
D	W7L	Gram Positive Cocci Vaccines	None
D	W7M	Gram Negative Bacilli (Non-Enteric) Vaccines	None
D	W7N	Toxin Producing Bacteria Vaccines And Toxoids	None
D	W7S	Antivenins ****Effective January 1, 2011**	None
D	W7T	Antigenic Skin Tests	None
D	W7U	Hymenoptera Extracts	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	W7W	Miscellaneous Therapeutic Allergenic Extracts	None
D	W7Z	Combination Vaccine And Toxoid Preparations	None
A	W8A	Heavy Metal Antiseptics	All
A	W8B	Surface Active Agents	All
A	W8D	Oxidizing Agents	All
A	W8E	Antiseptics, General	All
A	W8F	Irrigants	All
D	W8G	Miscellaneous Antiseptics	None
D	W8H	Mouthwashes	None
A	W8J	Miscellaneous Antibacterial Agents	All
D	W8T	Preservatives	None
PA	W9A	Ketolides	None
PA	W9C	Rifamycins and Related Derivative Antibiotics	None
PA	W9D	Glycylcyclines	None

Body As A Whole

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	Z1D	Enzyme Replacements (Ubiquitous Enzymes)	None
D	Z1E	Antioxidant Agents	None
D	Z1J	Metabolic Dx Enzyme Replacement, Mucopolysaccharidosis	None
A	Z2D	Histamine H2 Receptor Inhibitors	Cimetidine (generics only) Famotidine (generics only) Nizatidine (generics only) Ranitidine (generics only)
PA	Z2E	Immunosuppresives	None
A	Z2F	Mast Cell Stabilizers	Cromolyn sodium inhalation (generics only)
PA	Z2G	Immunomodulators	None
D	Z2H	Systemic Enzyme Inhibitors	None
D	Z2M	Immunosupp - Monoclon Antibody Inhibiting T Lymph Function	None
A	Z2N	1st Generation Antihistamine-Decongestant Combinations	Brompheniramine/Pseudoephedrine (generics only) Chlorpheniramine/Pseudoephedrine (generics only) Triprolidine/Pseudoephedrine (generics only)
A	Z2O	2nd Generation Antihistamine-Decongestant Combinations	Loratadine/Pseudoephedrine (generics only)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	Z2P	Antihistamine – 1st Generation	Chlorpheniramine Maleate (generics only) Cyproheptadine (generics only) Diphenhydramine (generics only) Hydroxyzine HCl (generics only) Hydroxyzine Pamoate (generics only) Promethazine (generics only)
D	Z2R	Leukocyte Adhesion Inhibitors, Alpha 4 Mediated, IGG4K MC AB Type	None
D	Z2T	Histamine H2-Receptor Inhibitor/Dietary Supplement Combinations	None
D	Z2U	Monoclonal Antibody-human Interleukin 12/23 Inhibitors	None
D	Z2W	Anti-CD20 (B Lymphocyte) Monoclonal Antibody	None
D	Z2V	Interleukin-6 (IL-6) Receptor Inhibitors	None
D	Z9D	Diagnostic Preparations, OU	None

APPENDIX G
DOCUMENTATION REQUIREMENTS(1)

In addition to the documentation requirements published by the American Medical Association in the Physicians' Current Procedural Terminology book, L&I or Self-Insurer has additional reporting and documentation requirements to adequately manage industrial insurance claims.

L&I or self-insurer may request the following reports. No additional amount is payable for these reports as they are required to support billing. L&I's Report of Accident or the self-insurer's Physician's Initial Report are payable separately. "Narrative report" as used in the table below merely signifies the absence of a specific form. Office/chart notes are expected to be legible and in the SOAP-ER format as specified under CHARTING FORMAT. Level of service is based on the documentation of services and the medical/clinical complexity as defined in the CPT Evaluation & Management (E/M) coding requirements.

Service	Code(s)	Requirements
Case Management, Telephone Calls and Online Communications	CPT® 99366-99368 CPT® 99441-99444 CPT® 98966-98969	Documentation in the medical record should include: the date, the participants and their titles, the length of the call or visit, the nature of the call or visit, and any decisions made during the call.
Chiropractic Care Visit	Local 2050A & 2051A	Office/chart notes
	Local 2052A	Narrative report or office/chart notes showing the increased clinical complexity
Consultation	CPT® 99241-99255	Narrative consultation report (WAC 296-20-051) due to the insurer within 15 days of consult
Critical Care	CPT® 99291 & 99292	Narrative report or daily chart notes
Emergency Room	CPT® 99281 & 99282	Report of accident and ER report/notes in the hospital medical record.
	CPT® 99283-99285	Report of accident and ER report
Naturopathic Care Visit	Local 2130A, 2131A & 2132A	Narrative reports and report of accident
	Local 2133A	Chart notes
	Local 2134A	Narrative report
Hospital	CPT® 99221-99223	Report of accident and H&P
	CPT® 99231-99238	Narrative report or an interval progress note
Nursing Facility	CPT® 99301-99303	Narrative report or facility notes and orders
	CPT® 99311	Narrative or an interval progress note
	CPT® 99312 & 99313	Narrative report or facility notes and orders
Office Visit	CPT® 99201 & 99202	Report of accident and office/chart notes due to the insurer in 5 days
	CPT® 99203-99205	Report of accident and office/chart notes due to the insurer in 5 days
	CPT® 99211 & 99212	Office/chart notes
	CPT® 99213-99215	Narrative report or office/chart notes showing the increased level of complexity
Prolonged Services	CPT® 99354-99359	Narrative or office/chart notes showing dates and times

Service	Code(s)	Requirements
Psychiatric Services	CPT® 90804-90853	Narrative report
Standby	CPT® 99360	Narrative or office/chart notes showing dates and times
Miscellaneous	CPT® 99288 & 99499	Narrative report or emergency transport notes

See WAC 296-20-06101 for any additional information

INDEX
MEDICAL AID RULES AND FEE SCHEDULES

- Only items with page numbers can be found within the policy manual.
  - 'Ctrl+click' on the page number to move to the page (must be in the main document)
- **RULES** can be found under **Medical Aid Rules**.
- **FEE SCHEDULES** can be found under **Fee Schedules**.
- Other Ways to Search This Document
  - Adobe Acrobat search in version 6.x sets up a hyperlink each time it finds the word you are trying to find. See HELP for more assistance
  - 'Ctrl+F' does the same as above
  - Table of Contents
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